Division or Vital Records, P.O. Box 68760.

within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral

State Registrar

29b. Signature and title of certifier

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year) FEB 25

29c. License number mp 0051268

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of verson who completed cause of death (item 23a) (Type, Print)

2008

8600 Old Georgetown Road, Bethesda, MD 20814 Nancy P. Lawless , M.D.,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32 egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:30 P_M **Physician** Ĭ̈́5, Minnie Nero February 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FT. Washington Health & Rehab. Center Fort Washington Prince George's 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5 Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 X F Director -16 - 1927428-64-7056 Belzoni, Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County wode the Medical Examiner must be notified at Prince George's 1 XYes 2 No MD Fort Washington Director or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a 12021 Livingston Road 20744 United States Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 6 21215-0036 1 ☐ Yes 2 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates "natural". Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygies Important: if item 27 ie marked other tt eny injury or other treumatic event, III.a. 12th Caregiver Private Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington Margaret (unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sylvia L. Jones (granddaughter) 2140 Alice Ave. Oxon Hill, MS 20745 Apt 204 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 2/25/2008 Brentwood, MD

22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funesal Service Licenses 3401 Bladensburg Road Brentwood, MD 20722 unay nom -23a. Part1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vascular Dementia /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760. To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Da 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9☐ Unknown 9 TUnknowi s been signed is should be det Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Feeding Dysfunction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Old Stroke page 2 1 ☐ Yes **2**√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes **※** No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury al Work? Certification: Division 1 Nalural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funerel Director: All completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 42955 2/19/2008 c. (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1310 Southern Ave. Suite 210 Edgar Potter, MD SEWashington, DC 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** Joseph Andrew Onley February 15, 2008 21:04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8815 Charm Court Brandywine Prince George s

9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1**1** M 2 □ F 73 4/22/1934 Director 579-48-5190 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified 1√Yes 2□No Directo Maryland | Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be 8815 Charm Court 20613 United States within 72 hours after death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1**X**Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Black 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Window Cleaner Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked of ၉ Alice Brown Raymond Onley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8815 Charm Court Brandywine, Maryland 20613
ace of Disposition (Name of Date 200. Location - City or Town, State <u> Joann Onley-Hall / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ty∏ Burial 2 □Cremation 3 □Removal from State Injury or National Harmony Mem. 2/23/2008 4 □ Donation 5 □ Other (Specify) Landover , Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arterioset erotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe ilcate has been siç r, page 2 should b 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe certificate ! Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1-Natural Injury 5 Pending To the Hospital or Attendir, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FFB 2 1 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07504 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:15 A 20, <u>Christina D. Psaras</u> February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 116 Spring Place Way Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/8/1940 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 1 F Months 229-78-1477 Director 67 Egypt Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐Yes 2 ☑ No Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 116 Spring Place Way 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 years Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil h and Mental H **is marked otl** Be Helen Bakides Constantine Digenis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I John D. Psaras/ Husband 116 Spring Place Way, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 🏋 Burial 2 □ Cremation 3 □ Removal from State Lakemont Cemetery 2/26/08 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Fire ray Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovaviau caucev Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deliving Cause (Disease or injury that initiated avents. Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and tile of certifier 29d. Date signed (Month, Day, Year) D19838 2/20/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bastg ate Rd. Annapolis, well 2/40/

Registrar

31. Date filed (Month, Day, Year) FEB 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day John Robert Pennington, Jr. /Medical February 22, 2008 02:50 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. Cify, Town, or Location of Death 4c. County of Death 18316 Winter Park Court Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 1 XM 2 F Director 210-12-2459 Yrs 80 1927 PÃ Usual Residence of Decedent the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sh ner must be notiffed Director MD Montgomery Gaithersburg 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Permit. Pages 1 and 2 should be filed within 72 hours after death very bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- any injury or other traumatic. 18316 Winter Park Court by Funeral 20879 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 17 Yes 2 1946 - If Yes, Give Year or Dates: 1947 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced 1947 Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry General Accounting Elementary/Secondary (0-12) College (1-4or 5+) Auditor Office 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Robert Pennington ပ Agnes Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Msgr. John Robert Pennington 10103 Georgia Avenue Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 25 4 Donation 5 Other (Specify) All Souls Cemetery Germantown, MD 2008 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Our and Dean UNC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. File Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) Month Day the Year 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No Certification: To Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🔲 Inpatient this 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 2 Accident

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: After Director:

1+1,

3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Within 24 hours after To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Defining Physician. To the basis of my knowledge, deall occurred at the time, date and place, and due to the cause(s) and mainer as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number

1 ☐ Yes 2 ☐ No

person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of MALLMARK 9707 Mechal

31. Date filed (Month, Day, Year) FEB 25 2

Registrar's Signature

State

Registrar

			For State Registrar	State of	Maryland / De <i>C</i>	partment o <i>ertificate d</i>			giene Reg. No. 2008 07	1506					
	A. p.	-	Decedent's Name (First, Midd	le, Last)			***	2. Date of De	eath 3. Time	of Death					
8	Physici /Medic		Obadiah Willi	am Person.	Jr.			Month Februa	ry 15, 2008 11:	42 M					
	Examir		4a. Facility Name (If not institution			4b. City, Tow	n, or Location of D		4c. County of Death						
			Prince George	's Hospital	1.	Cheve	rly		Prince Georg	ge's					
6.	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda	Months Da		Hrs. 8. Date of Bir Min. (Month, Da	th 9 Rirthplace (Stat						
e.	Director		224-54-3126	1 X M 2 □ F	69 Yrs	Months Bo	iyo mada	Oct. 1	0, 1938 North Car	colina					
	p ,	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			40d Incide	City Limite					
	anyla shov	-	Toa. State Tob. County	•	Too. Oity, Town of	Location				e City Limits es 2 □ No					
	8a-f	ecto	Distinct of	Columbia	Washi										
	or 2	ij	10e. Street and Number			10f. Zip Cod	ie		10g. Citizen of What Country?						
	ath v	ral	918 Eastren			2001			United States						
	er de Items	Funeral Director	11. Marital Status	12. Was Decede	es?	3. Was Decedent If Yes, specify (of Hispanic Origin Cuban, Mexican, F	i? (Specify Yes or No Puerto Rican, etc.)	 14. Race - American Indian, Black, White, etc. 						
36	or ", or		1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	□ NO	1 ☐ Yes 2 ☐	No Specify:		Specify: Black						
Ş	hour tural	pe pe	Λ	nt's Education		cedent's Usual Oc	ecupation		16b. Kind of Business/Industry						
15	n 72 i "na ledic	Set	(Specify only high	est grade completed)	(G	ive kind of work do . DO NOT use re	one during most of stired)	f working	Tob. Kind of Edamess/Industry						
21215-0036	withi ene. thar thar	Completed by	Elementary/Secondary (0-12)	College (1-4	or 5±1	puter Te			Private						
d 2	Hygi Hygi ther int, t	ပိ	17. Father's Name (First, Middle	, Last)			18. Mother's	Name (First, Middle	, Maiden Surname)						
Maryland	ould be filed within 72 hours after death with the Manyland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show artic event, the Medical Examiner must be notified at	To B	Obadiah Willi	am Person.	Sr.			herine Do							
=	E E E	F	19a. Informant's Name/Relation	··		ailing Address (Str			er, City or Town, State, Zip Code)						
\mathbf{z}	nd 2 sho Ith and 27 is ma	Ш	Adrienne L. N			-			e, MD 20613						
ည်	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			sposition (Name o		Date	20c. Location - City or Town, State						
no	ages int of t: if if		1 Magazian 2 ☐ Cremation					ь 26, 200	8 Triangle, VA						
Baltimore	iit. Partme		4 ☐ Donation 5 ☐ Other (Quantit				uneral Home, Inc.						
Ba	permit. Pages 1 and 2 s Department of Health ar important: if item 27 is any injury or other trau		MM	61016	IN 1 + C.s										
			23a, Part I. Exter the disease, of	3a. Parti. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
		. Y - N	shock, or heart failure. Lis Immediate Cause (Final					adde of roophatory o	Interval E Onset an	Between					
	Physician /Medicai		disease or condition resulting in death)	a	l Cardiac A	rrnytnmı	a								
	Examiner		Due to (or as a consequence of): Hypertension												
		<u></u>	Sequentially list conditions,												
	led Isit	i	Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Diabetes Mellitus C. Due to (or as a consequence of):												
	and and	xan	that initiated events resulting in death) Last	C	as a consequence of):										
8760,	icate be executed physician and s the burial-transit	dical Examiner													
	icate phys s the	dic		d											
×	death certific e attending p id for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy				22.2.4.4.1						
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birt	h 2 Fetal death	3 □Ectopic pregna 5 □ Other (specif)			23d. Date of delivery Month Day	Year					
Ö	0 0 0	ysic	1 ☐ Yes 2v ☐ No 9 ☐ Unknown	9☐Unknow		o □ Other (specif)	//								
۵.	requires that the death een signed by the atte nould be detached for	P	Part II. Other significant condit	ons contributing to deat	h but not resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contribute to the cause of	of death?					
ds,	signe signe	þ			3	,	9		Yes 2□No 3□Probably 4X	_					
Records,	requ	stec		·				_							
Sec.	e 2 sh	ngl						— 24a. Was	psy prior to completion of	gs available of cause of					
<u>=</u>	: The lav	Completed			_			perio 1⊟ Yes	ormed? death? 2∑XNo 1 ☐ Yes 2 ☐ No						
or Vital	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medica examiner?			· · · · · · · · · · · · · · · · · · ·		Death (Check only	one)						
Ž	Physi this o	၉	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inp		IEIK 3 DOX		ng Home 5 ☐ Res	dence 6 Other (Specify)						
n			27. Manner of Death 1 XNatural 5 ☐ Pendi	28a. Date of (Month,	Injury 28b. Time Day Year) Injur		njury at Work?		how injury occurred						
<u>si</u> 0	Attending r death. ector: After y the fune	ati	2 ☐ Accident invest	igation		M	1 ☐ Yes 2 ☐ No								
	irect irect	ŭ	3 Suicide 6 Could 4 Homicide determ	nined 200. Place of	injury - At home, farm, , etc. (Specify)	street, factory, off	ice	28f. Location (City or To	Street and Number or Rural Route N wn, State)	umber,					
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:													
	hon leiv fil								cause(s) and manner as stated. date and place, and due to the caus	e(s)					
	the I	Medical	one)	and manne	stated.										
	To To	2	29b. Signature and title of certific	er //	/	29c. Lic	ense number	_	29d. Date signed (Month, Day, Year)					
	1/1/			1/4	els	(058957	7	2-18-08						
(Tran		30. Name and address of perso	who completed cause	of death (Item 23a) (Typ	e, Print)	,								
	ge		Dr. Gary Litt	1e 3001 Hos		e Chever	ly, MD 2	0785							
	Sta		FFB 2 1 2008	32. Reg	istrar's Signature										
	Registr	ar	FFE C T COOL	Manage and a Mile											

per phy., 02/19/08, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Morrebruary Pr, 2008 Year **Physician** William Wilson Potts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Allegany Examiner Frostburg 230 Shaw Street 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 93 Davs Hours Min. 164-09-0622 1 M 2 □ F Permsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notifiled at Delaware Philadelphia Pennsylvania 1 XYes 2 □ No Director 6492 Drexel Avenue 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 19151-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: W.W.II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry O College (1-4or 5+) Elementary/Secondary (0-12) Pressman **Printing** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked oth Ella Easterday Robert Potts ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Maryland 21532-Frostburg Marie Potts-Deakin 230 Shaw Street 20b. Place of Disposition (Name of cemetery, crematory or other p. 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State February 21, 2008 St. Peter & Paul's Cemetery Springfield Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days **Physician** te /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): physician and s the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical SB IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō Month Year in the past 12 months? Day 5 Other (specify) signed by the at d be detached for ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 150A5E 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1∐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only_one) 5 Linesidence 6 Nother (Specify Home Other: 4 Nursing Home 1 Yes 2[No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou. *he Funeral I' To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 5+ 30. Name and address of person who npleted cause of death (Item 23a) (Type, Print) WAISH DR Lumberland NAS 31. Date fled (Month, Day, Year) State 1 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Amended #26, nls,

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Пау Month Year 50 AM Komne **Physician** 12 OX 190 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arund Annepali If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 □ F **Director** Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10h Count ir than "natural", or itsms 23a or 28e-f show the Medical Examination must be notified at 1 ☐ Yes 2 ☑ No m Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 50 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 90 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) if itsm 27 is marked other or other traumatic svant, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental h Pages 1 and 2 should be Somett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20754 m Hills if Item 27 Rd 7511 Garrison samionk 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 2/21/2008 Baltimore, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e.j.of line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 50 minutes Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical 25 ettending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 ☐Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the eld 9∏ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificete hes t lirector, page 2 s autopsy performed? 2 No 1□ Yes Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 NInpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No death within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day, Year) cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month. Day, Year) State FEB 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Day Month Physician Edna Nice Robinson 0930m February 24 /Medical 4a. Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 1 5. Social Security Number 9. Birthplace (State or Foreign ^{Year)} 1934 **Funeral** Days Months Hours Min. 1 M 2 F Maryland 214-36-5785 73 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 □Yes 2 X No Director MD Dorchester Wingate Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-uny or other traumatic event, the Medical Examiner must be notif Robinsor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21675 USA 2111 Farm Creek Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No white Specify: Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lehman Moore Gladys Marie Bloodsworth ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda D. Bradford 103 Belvedere Ave., Cambridge, MD daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 2/27/08 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 5 700 Locust St., Cambridge, MD 23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 10/06 /Medical Due to or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2 No detached the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 💢 No 1 Tes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform this certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ٩ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Division or Vital Records. or Attending Physiclan: within 24 hours after death.

To the Funeral Director: / the Hospital

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

63359

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RN ST, CAMBRIDGE

State Registrar

31. Date filed (Month, Day, Year) FEB 2 2 5 2008



Year

3:30 P M

3. Time of Death

Birthplace (State or Foreign Country)

WASHINGTON, DC

10d. Inside City Limits

tx⊡Yes 2 □ No

WHITE

20852

Year

2 YEARS

2 YEARS

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Physician
/Medical
Examiner

Funeral Director

filed within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Director Funeral ģ Completed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth, any Injury or other traumatic event, once. Be 2

Maryland 21215-0036

Baltimore,

Physician /Medical Examiner Examiner

certificate be executed

O. Box 68760

Records,

or Vital

sician and burial-tran physiciar as attending properties for use as signed by the a this c After this funeral c vithin 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral

Physician/Medical

<u>\$</u>

Completed

Be

2

Certification:

Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month PAUL BUDD RUBIN FEBRUARY 20, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4801 FAIRMONT AVENUE #610 **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 11 M 2 □ F Yrs. 65 02/08/1943 218-38-7667 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4801 FAIRMONT AVENUE #610 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2½∑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WASHINGTON TALENT College (1-4or 5+) Elementary/Secondary (0-12) CO-OWNER AGENCY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRVIN RUBIN FRANCES FLAX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4916 BUTTERWORTH PLACE, NW, WASHINGTON, DC 20016 ce of Disposition (Name of Date 20c. Location - City or Town, State DONA S. LENKIN/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State KING DAVID MEML GDNS 02/24/2008 | FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signs Import unteral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a CORONARY ARTERY DISEASE Due to (or as a consequence of): b. ATHEROSCLEROTIC VASCULAR DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equentially list conditions Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 HInknown

25. Was case referred to medical examiner?

1 XYes 2 No

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4□Pregnant at time of death

9□Unknown

3 Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TYPE 2 DIABETES, BIPOLAR DISORDER

HYPERTENSION, HYPERLIPIDEMIA

5 ☐ Pending investigation

6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D38152

1 X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) FEBRUARY 21, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed? 1□ Yes 2 No

Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tarbour

2008

DR. DEBORAH J. BARBOUR, 5454 WISCONSIN AVENUE, SUITE 925, CHEVY CHASE, MD 20815

State Registrar 31. Date filed (Month, Day, Year) FEB 2 5

29b. Signature and title of certifie





2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 18, 2008Physician February Rich 11:53 A M Evelvn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cheverly Prince George's Community Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1-6-1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 🙀 F Charleston, SC 577-50-8754 72 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ordrant: If fiem 23a or 28a-f show fortant: If fiem 2 marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 1√Yes 2 No Funeral Director MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7801 Barlow Road Apt 307 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Babysitter Childcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simmons Richardine Abraham Hainesworth ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5612 Greenleaf Rd. Cheverly, MD 20785 Jacqueline Rich (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Fort Lincoln Cemetery 2/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Gensee 3401 Bladensburg Road Brentwood, MD 20722 hope uhaul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the story are fidying, such as cardiac or resuratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9□ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 3 Probably 4 Unknown 1 ☐ Yes No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy (performe 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To npatient 27. Manner of Death 1 De Natural 28c. Injury at Work? 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2/Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
FFR 2 1 2008

32. Registrar's Signature

39 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany
9. Birthplace (State or Foreign WMHS-Frostburg Nursing + Rehab CHR 5. Social Security Number 6. See 7. Age (In yrs. last birthday) Frostb 8. Date of Birth (Month, Day, Year) 01/20/1939 5. Social Security Number **Funeral** 1 □ M 2 🕱 F Months 214-62-4640 69 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ RR 1 Box 275 BB USA 26753 'natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Exminer must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify þ 3

Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Theodore Noel Veronica Katherine Bierman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianna D. Howard / Daughter 1 Box 275 BB. Ridgelev. WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 02/20/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home. P.A. 21. Signature of Funeral Service License 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** disquise 5 tance Chronic 6 months /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown the 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe certificate 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 1 ☐ Yes 2**X** No 1 | Inpatient 2 ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural
2 Accident 1 □ Yes 2 □ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

2

31. Date filed (Month, Day, Year)

Wonsock Shin MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BISHOP WALSH RD 32 Registrar's Signature

Cum benand

21532

29c. License number

00055325

WONSOCK SHIN MD.

29d. Date signed (Month, Day, Year)

Feb 15, 2008

Division or Vital Records. P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khenna Shiv 31. Date filed (Month, Day, Year) State FEB 1 5 2008 Registrar DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of Certifier

and manner stated.

MD

Calak

29d. Date signed (Month, Day, Year)

1 Lertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

East Neitional Highway

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2008 1414 Kent Fuller Stewart March 3. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Harford 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/30/1935 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F 72 Yrs. Director 212-30-8636 Usual Residence of Decedent New York with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Harford 1 SYes 2 □ No Aberdeen 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 525 Windemere Dr. 21001 U.S.A. 12. Was Decedent Ever in U.S.
Amed Forces?

Layes 2 □ No
Hyes, Give
Year or Dates Nat. Guard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laurence G. Stewart Ruth Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie M. Stewart (Spouse) 525 Windemere Dr. Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Important: if it en eny injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R. A. Ferris & Co. 3/5/08 West Chester, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serface Licenses 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque inding physiclen and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular disease 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter deat To the Funaral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and class, and due to the cause(s) and number is stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) D 0063981 March 4, 2008 M.D. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havrede Grace, MD Benjamin Lee, MD 669 Revolution St. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 7 2008 State Registrar DHMH 17 Rev 1/2001

ORIGINAL

IENDARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth 1.00 PM Ann 02 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Hartor Hechical If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) ZZ Months 1 □ M 2 💢 F Hours Min. 217-16-635 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No other traumatic event, the Medical Examiner must be notified **Funeral Director** Jarrettsville MD. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23a 1741 W. Jarrettsville Road 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after all Hygiene. other than "natural", or Itel 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Mental Horace Nelson ဥ Lucy Pearl Gorman 19a. Informant's Name/Relationship (Type. Pr(ht)Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 1 and 2 1741 Jarrettsville Rd. Jarrettsville.Md. Patricia A. Barwick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 altimor important: if it any injury or o 1 Burial 2 ☐ Cremation 3 ☐Removal from State Wesley Chapel Cem. 3/5/2008 Monkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland Kurtz & Son Funeral Home. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Motension arry Hunders Cardiac 12 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Congestive heent Examiner Ormary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner 20.4eau attending physician and for use as the burial-transi Africel bibrulcetion Chronic that initiated events resulting in death) Last Due to (or as a consequence of) Hypertension >20 years Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 210/No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this. 27. Manger of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 | Pending 1 □ Yes 2 □ No death. Investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide ō Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065641 Kamal Bangowa, 08

State Registrar KAMAL

31. Date filed (Month,

G.

DHMH 17 Rev 1/2001

upper chearapeable Meelical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BANGORIA

32. Registrar's Signature

upper chesopeers drive

MO-21014

			1 _ State	of Maryland		rtment of H tificate of L			liene 2	008	07516
	*	3	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physicia /Medic		Rose Sara Sege	rstrom				Februar		2008	8:51 A M
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or				nty of Death	
		. 41	Spa Creek Center 5. Social Security Number 6. Sex	7. Age (In yrs. la	st hirthday)	Annapoli If Under 1 Year	.S If Under 24 Hrs.	8. Date of Birth	1	e Arui	hplace (State or Foreign
	Funeral Director		577-01-8041		Yrs.	Months Days	Hours Min.	10/28/	, <i>Year)</i> 1916	Was	hington, D.C
a mark to	pu ,		Usual Residence of Decedent	10c City	Town or Loc	cation					10d. Inside City Limits
	faryla shov ed at	ō	10a. State 10b. County								1 ☐ Yes 2 No
	the N 28a-i notifi	Director	Maryland Anne Arundel 10e. Street and Number	Davi	idsonv	10f. Zip Code			10g. Citizen o	of What Co	untry?
	h with 23a or st be	al Di	3520 Russell Thomas La	ne		21035		Ţ	Jnited	State	es
	r deat	Funeral	11. Marital Status 12. Was Arme	Decedent Ever in U.S d Forces? es 2 🖸 No	3. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Ame	rican Indian, e, etc.
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Fu	v If Yes	es 2 🔼 No , Give or Dates:	1	I∐Yes 2XINo	Specify:		Spe	cify: Wh:	ite
3	2 hour	ted	15. Decedent's Education	- 1	16a. Deced	lent's Usual Occupa	ation	ina	16b. Kind of		
7	thin 7 le. lan "n Medi	Completed	(Specify only highest grade completed and Secondary (0-12) Elementary/Secondary (0-12) College	ge (1-4or 5+)		kind of work done o OO NOT use retired))	my .	Reta:	; 1	
7	led wi fygien her th ht, the		17. Father's Name (First, Middle, Last)		Sales		18. Mother's Name	e (First Middle			
	d be fi	Be c	Placido Bonanno				Rosaria			amej	
2	should nd Me mark matic	P_C	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street &				vn, State, Z	Zip Code)
<u> </u>	and 2 saith a n 27 is ier trai		Linda C. Razzano/Daugh	ter	3520	Russell T	Chomas La	ne, Dav	idsonv	ille,	MD 21035
ע	es 1 a of He of He or otho		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal f	20b. Pla ce	ace of Dispos emetery, cren	sition (Name of matory or other plac	e)	Date	20c. Locatio	n - City or	Town, State
	thent of I		4 □ Donation 5 □ Other (Specify)	Gate	e of H						ng,Maryland
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Flureira Service Licensee			. Name and Addres 2973 So1o					eral Home MD 21037
F			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. on each line.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	indiac a	rrest	-					Onset and Death
	/Medical Examiner		Du Du	e to (or as a consequ	ence of):	Leanes	,				
		ler	Sequentially list conditions, if any, leading to immediate	e to lor as a nansequ	ence of)	Justine					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a conseque to or as a nonseque to or as a conseque by bor as a conseque	dem	ia					
0/00,	icate be executed physician and s the burial-transit	EX	resulting in death) Last Du	e to for as a consequ	ence of):						
00	icate I physi s the k	dical	d								
XO2	n certii ending use a	n/Me		, outcome pf pregnar ive birth 2 □ Fetal		Ectopic pregnancy			23d.	Date of del	livery
2	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	In the past 12 months? 1 ☐ Yes 2 █ No 4 ☐ F	regnant at time of de Inknown		Other (specify)				Month	Day Year
г 5	hat the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing		Itina in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
ecords,	uires t signe Id be	d by	Hosentension			, , ,		1 🗆 1	res 2 ⊠No	3 □ Pr	robably 4 □Unknown
5	aw req	Completed	Congestive heart for	ilwe				24a. Was		b. Were au	utopsy findings available
ř	The Is	mo						autop perfo 1⊟ Yes	rmed? 2.⊠No	death?	completion of cause of : 2 □ No
N I Call	ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat		-		
5	Physic this o	P_	1 ☐ Yes 2 No Hospital:		ER/Outpatien		4 Nursing Ho	ome 5 Resid			city)
Sion	ding I h. After funer	tion:	1 Natural 5 Pending	Month, Day Year)	Injury	Worl	yai k? Yes 2 □ No	28d. Describe	iow injury oci	Juneu	
S	Atten r deat ector: by the	fica	3 Suicide 6 Could not be determined 28e. I	Place of injury - At hor	me, farm, str	eet, factory, office		28f. Location (S City or Tov		mber or Re	ural Route Number,
5	tal or rs afte al Dir ed in l	Certification:	4 Homicide	ouilding, etc. (Specify				Only or Tov	m, State)		
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier 1 Check only one) 1 Certifying Physician: T								
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. License	e number				th, Day, Year)
			ManelGresse	Colle		D002	5134		2-2	10-0	78
(113		30. Name and address of person who completed Carol A. Pressey, M.D	cause of death (Item		Print) on St, #10	O1 Edges	ater M	2103 ת	7	
	Sta	ite		32. Pigistrar's Signat			or, nugew	acci, M	<i>L</i> 2103		
	Registr	ar	FEB 2 2 2008	Marie 1	O. A	DENE					

			State of Maryland / I					_	07517
			1 - State Registrar		tificate of D			2 U U Ö g. No.	0/3//
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	ELLEN HARRIS SHORTER		4b. City, Town, or	Logation of Dogsth	FEBRUARY	7 19, 2008 4c. County of Death	10:55 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 411 COMMERCE STREET		HURLOCK	Location of Death		DORCHEST	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		219-42-9016 1□M 2X F 64	Yrs.	William Days	Hours Will.	AUG. 14,	1943 MARY	LÁND
	land ow II		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Loc	ation				10d. Inside City Limits
\bigcirc	Mary Ff eh	tor	MARYLAND DORCHESTER HURL	OCK					1∭Yes 2☐No
2)	death with the Maryland me 23a or 28a-f ehow rintal be rediffed at	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
ζ	23e	ral	411 COMMERCE STREET	1.0.11	1	1643		USA	to an in diag
7	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No		as Decedent of His Yes, specify Cubar		Rican, etc.)	14. Race - Amer Black, White	
036	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	☐Yes 2XX No	Specify:		Specify: WI	HITE
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ē	Pages ent of nt: tf ii		1 ØBuriai 2 Cremation 3 Hemoval from State		atory`or other place MEM • PARK	2/23/	2008	CAMBRIDGE,	MARYLAND
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: if item 27 is marked eny injury or other treumatic ev once.		21. Sign, ture of Funeral Service Lionnee	22. 7 F	Name and Address	of Facility			
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ı		(233 Party Enter the disease, or comblications that caused the death. Do thick, or heart failure. List only one caused on each line.				r respiratory arre	st,	Approximate Interval Between Onset and Death
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P.O.	the c	hysl	1 Yes 2 ANO 9 Unknown						
	w requires thet the s been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	n in Part I.	1	acco use contribute to	
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tal	an: T tificete tor, pa	0	25. Was case referred to medical			26. Place of Death	1 Yes 2		2 5 No
<u>></u>	hysicl his cer I direc	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/O	utpatient	3□ DOA Cthe	r: 4 🗌 Nursing Hor	ne 5 Resider	nce 6 Other (Spec	ufy)
S C	ling P		1 Statural 5 ☐ Pending (Month, Day Year)	Time of Injury	28c. Injury Work' M 1 TY		28d. Describe ho	w injury occurred	
/isic	Attend r death octor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for	arm, stre		es 2 No		eet and Number or Ru	ral Route Number,
á	rs after at Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)				City or Town,	State)	
	To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	e, death nd/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Month	. Day, Year)
•	1		11/19/1 tokelinus		D26	1388	F	25,21	1000
	10		30. Name and address of person who completed cause of death (Item 23a) Michael Faddew MD 3c 31. Date filed (Month, Day, Year) FFR 2 2 2008	(Type, F	collins	me H	ur loc	k md 7	1643
	Sta Registr	te ar	FEB 2 2 2008	k /	fort		4		

State of Maryland / Department of Health and Mental Hygiene (State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 16, 2008 Jerome Smith February 1645 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges' Community Hospital Cheverly 8. Date of Birth (Month, Day, Year) 06/22/1953 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours 1₩ 2□F 578-70-6903 54 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. Count 10c. City. Town or Location 28a-1 show e filed within 72 hours after death with the Maryla at Hygiene. other than "natural", or Itema 23a or 28a-4 shov vent, the Mydical Examiner must be notified at D.C. Washington 1 XYes 2 No Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1015 - 48th Place, N.E. 20019 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metal Stud Mechanic Private permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygien
Important: If item 27 is marked other tt
any injury or other traumatic avent. The 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernell E. Smith - Wife 1015 - 48th Place, N.E.; Washington, D.C. 20019 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 02/19/2008 | Beltsville, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Sign the of Funeral Service License 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (of as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 2 No certificate 1 ☐ Yes Division of Vital funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Medical Certification: To 28b. Time of 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thours efter death.

-unerel Director: A
ely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: Op me basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Ihe I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive Gary FEB 2 Month, Pay 6 State

Registrar

For

			Registrar			Ce	rtificate	of L	Death			Reg. No	$L \subseteq U \cup U$	0	UI	015
			1. Decedent's Name (First, Middle,	Last)			-				2. Date of De	eath Da	y Ye	or I	3. Time o	f Death
	Physici /Medic		Carol		Lee		Sprig	gs					20. 20	1	18:	05 ^M
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, To	own, or	Location	of Death			. County of E			
			WMHS - MEMOR	RTAL CAM	PUS		CI	UMBE	RLAN	D			ALL	EGAI	JY	
A 60-	Funeral			3. Sex		s. last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bi	Birth 9. Birthplace (State or Foreig Country)			or Foreign	
	Director		213-44-1798	1 □ M 2 🔀 F	63	Yrs.	Months	Days	Hours	Min.	11/22/	1941	M.		land	
Ī	-g		Usual Residence of Decedent				<u> </u>									
	rylar how		10a. State 10b. County		10c. C	City, Town or Lo	cation							10	d. Inside C	
	a-fs	cto	MD Alleg	gany		Cu	mberla	and							1 X Yes	2 □ No
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	deat ms	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decede		-	igin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - A			
٥	after or ite		1 ☐ Never Married 2X Marrie		2 X No aive						rican, etc.)		Black, V	vnite, e	tc.	
0000	ral",	b	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:		1 ☐ Yes 2[X NO	Specify:				Specify:	lac	k	
ק ה	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education	n	16a. Dece	dent's Usual	Occupa	ition	et of worki	'nα	16b. K	and of Busine	ess/Inde	ustry	
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o.	should be ind Mental marked or imatic eve	10	Charles			Pope			Gre	etche	n			G	ordon	l
2	2 should and Men is marker aumatic		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Street a	nd Numb	er or Rura	al Route Numb	er, City o	or Town, Sta	te, Zip (Code)	
Ξ	요두다후		Ralph U. Sprigg	s, Jr./h	usband	866	Maryl	and	Aven	nue,	Cumber:	land	, MD	215	02	
ก	s 1 a f He f Hem Item othe		20a. Method of Disposition		20b	Place of Dispo	sition (Name	e of	2)	C	Date	20c. Lo	ocation - City	or Tov	vn, State	
Dallimor	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ Other (Sp.		ii State	. Mary			a a	12/25	/2008	C113	mberla	nd	MD	
┋	artm ortar		21. Signature of Funeral Service L		100						ms Fam:					P.A.
Ö	permi Depa Impo any Ir		Man Ch	(Ida	m/						Cumber				502	
			23a. Part1. Enter the disease, or o	omplications that	caused the de					<u>·</u>			-,		Approxima	te
			shock, or heart failure. List o Immediate Cause (Final	nly one cause on	each line.	5	1.00								Interval Be Onset and	tween Death
	Physician / /Medical		disease or condition resulting in death)	_a. 1/19	UCHK	DIAL	LIL	JF1.	KC	not	U				WDD!	7U_
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		<u>.</u>	Sequentially list conditions,	b. —	(or as a cons	estacina fir						_				
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00/00	certificate be executed rding physician and use as the burial-transit	/Medical	· ·	d										+		
×	n certifii nding puse as	Me	IF FEMALE:	000 16 1100						-						
2		_	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf preg birth 2 □ Fe	etal death 3	Ectopic pre						23d. Date of Month		y Day	Year
-	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre 9□Unk	gnant at time of nown	f death 5	Other (spec	cify)					· · · · · · · · · · · · · · · · · · ·		,	, 54.
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ń	es the igner	þ	Part II. Other significant condition	A A \) \cap	esulting in the u	nderlying cau	use give	n in Part i	l.			use contribut			,
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>	ysici is cel	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3□ DOA	Othe			me 5□Res		6 □Other (Snecify		
5	g Ph er th		27. Manner of Death		e of Injury	28b. Time o	f 28	c. Injury Work			28d. Describe		<u>_</u>	SPCONY)		
	th. :: Aft	턀	1 Natural 5 Pending 2 Accident investiga		nth, Day Year)	Injury	м		? ′es 2 🗌	No						
2	Atter dea ector	fice	3 Suicide 6 Could no	od Zoe. Flat	e of injury - At	home, farm, str	eet, factory,	office		2	28f. Location	Street ar	nd Number o	r Rural	Route Nui	nber,
5	after Dire	Certification:	4 ☐ Homicide determin	buil	ding, etc. (Spec	city)					City or To	wn, State	B)			
	splta nours nera nera / fille			Physician: To the												
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for use	Medical		xaminer: On the												(s)
	omp	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	ite signed (M	lonth, D	ay, Year)	
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	5		30. Name and address of person w	h completed as	rea of death (It		Print\	10	UD-	700		-	-/-	1 /		
	nes		KHANNA, SHIV					НСН	WAY.	T.AV4	ALE. MT	215	502			
	Sta	to	31. Date filed (Month, Day, Year)		Pristrar's Sig	nature			9	-117 A L	9 111					
	Registr		FEB 2 2		Si Side	J. 19	me									
				- Art												

Amended #23a(c), nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 02/15/08, State of Maryland / Department of Health and Mental Hygiene Allegany Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HARVEY CHARLES SMITH JR 02 13 12:19 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X** M 2□ F Director 8-24-1942 174-34-9418 65 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2 No Director Bedford PA Hyndman the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e ms 23a 15545 4468 Hyndman Road USA filed within 72 hours after death ral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>ک</u> White 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Bicycle Manufacture item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked ol ဥ Harvey Charles Smith Sr Peal Alzene Mull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hyndman, PA <u>4468 Hyndman Rd.,</u> Shirley A. Smith/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lybarger Cemetery 2-16-08 Buffalo Mills, PA 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service Licens Home 169 Clarence St., Hyndman PA e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use only one cause on each line. 23a. Part1. Inter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) multiple organ Physician /Medical Due to (or s a conseque e of): Examiner Shock Sequentially list conditions, dary, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner The law requires that the death certificate be executed Probable Bacteremia onysician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? for Day 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy perform 2 **1** No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Hospital or Attending Physician: within 24 hours af
To the Funeral D
completely filled in

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State Registrar

30. Name Heven

(Check only one)

29b. Signature and title of certifier

Jmith 31. Date filed (Month, Day, Year) FEB 1 5 2008



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D0018216

and address of person who completed cause of death (Item 23a) (Type, Print)

Cumberland, Maryland Daive

DENGE !

			1 - For State Registrar	State of Maryland		nent of H			giene 2008	07521
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Lester	Shaw				2. Date of Dea Februar	th Day Year	3. Time of Death
9	Examir			real Hospita	11 0	-amb	Location of Death		Dorche	ster
	Funeral Director		5. Social Security Number 6. Sex 150-70-1565 Usuel Residence of Decedent	M 2□F 7. Age (In yrs. last		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bin 12 1940 5'0 L	hplace (State or Foreign buntry) Lth Carolina
343	the Maryland 28a-f show notified at	Director	M.D Dorche		own or Location	dge				10d. Inside City Limits 1
3.	th with 23a or	Funeral Dire	10e. Street and Number 8 0 4 Pine 11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 D No	13. Was I		ispanic Origin? (Sp an, Mexican, Puerto		10g. Citizen of What Co 2 S A 14. Race - Ame Black, Whit	nican Indian,
15-003	"netur	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	completed)	6a. Decedent's		during most of work	ing	Specify: Blo	ack (Industry
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LESTE F Baltimore, Maryla	permit. Pages 1 end 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then eny injury or other treumatic event, Ite Mance.	To	19a. Informant's Name/Relationship (Type) 19a. Maggle S 20a. Method of Disposition 1 Burial 2 Micromation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	havy 20b. Place ceme Aid S	700 H of Disposition	Mame of or other place	treet Ca	Mbrid	r, City or Town, State. Ge Mayya Cor. Location - City or Cambridee	Nd 2/6/3 Town, State
8760, F	Physician /Medical Examiner	dicai Examiner	23a. Park Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or as a conse	ce of):	WOSI	g, such as cardiac	oti Cal	uprida Pi	Approximate Interval Between Onset and Death month days days
P.O. Box 68	The law requires that the death certifica Ite has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. II yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3 ☐Ecto	pic pregnancy er (specify)			23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed by should be deta	Ď	Part II. Other significant conditions conf	tributing to death but not resultin	g in the underly	ing cause giv	en in Part I.		bacco use contribute to	o the cause of death?
al Reco	w	Completed						24a. Was a autop perfor	24b. Were at prior to death?	utopsy lindings available completion of cause of
Division of Vital Records,	afing Phy	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		/Outpatient 3 b. Time of Injury	DOA Cth 28c. Injun Worl	4 Nursing no	me 5 Resid	ence 6 Other (Spe ow injury occurred	ocify)
Divis	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				City or Tow		
	To the Hospital within 24 hours of To the Funerel I completely filled	Medicai	one) 21 Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occi and/or investig	ation, in my o	pinion, death occur	red at the time, o	date and place, and due	to the cause(s)
	To with	2	29b. Signature and title of certifier A · Labib	MD		29c. Licens	o6552, bridge	•	02/18/	
	Sta	ite.	31. Date filed (Month, Dey, Year)	D 300 Byri 32. Egistrar's Signature	n 5+	Can	nbridge	WD 3	1613	
	Regist		FEB 2 7 20	US Assessor A	A CONTRACTOR					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 11:50 A M Ethel Smith February Mav 2008 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Frostburg Nursing & Rehab Ctr. Frostburg Allegany 8. Date of Birth (Month, Day, Year) 10/23/1916 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F 91 Pennsylvania 220-34-1232-A Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Director MD Allegany Flintstone 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be USA 21530 12202 Town Creek Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify. Specify: þ er than "natural", c 3 X Widowed 4 ☐ Divorced ear or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) H<u>ome</u> Ith and Mental Hygier 27 is marked other the traumatic event, the 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weicth Shipley Amanda Albert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 21530 Linda J. Smith / Daughter-in-law 11814 Town Creek Road, Flintstone, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Fairview Christian Cem 02/21/2008 Inglesmith, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service License 21502 404 Decatur Street, Cumberland, MD 1 Day 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2 days Asciration Procumonia /Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Severe Dementia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🕅 No 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Hlnknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension autopsy perform 1□ Yes 2 🔀 No Gout 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 \boxtimes Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide filled e Funeral (1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifier D14464 February 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 48 Tarn Terrace, Frostburg, MD 21532 MLS Sandhir, Sikander L.

State Registrar 31. Date filed (Month, Day, Year) FEB 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Year TRUE, SR. 04: 40 PM FEBRUARY 2008 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTI MORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours 1 X M 2 □ F 90 578-09-1512 Washington, D.C Sep. 04,1917 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pasadena 1 ☐ Yes 2 X No MD Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 1528 Marco Drive 21122 Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Withers Harry S. True 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis P. True, Jr./ Son 8715 Warm Waves Way Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 10ms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 33 days PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): ACUTE KENAL FAILURE Due to (or on a consecuence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? Month Year 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown HIPOCALCEMIA 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner

signed by the attending physician and a betached for use as the burial-transit

this certificate has been sral director, page 2 should

funeral director,

Physician/Medical

Completed by

Be

Medical Certification: To

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Be

item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic events.

3altimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to infine hate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

27. Manper of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

MP

ES 000

15,2008 FEBRUARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STREET, BALTIMORE, MD PANWAR BHUPESH 3001 SOUTH HANOVER

31. Date filed (Month, Day, Year) FEB 2 2 2008

32. Redistrar's Signature Elecus

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb. Physician 17,2008 11:45aM Carolyn M. Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kris Leigh Assisted Living Anne Arundel Severna Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 7, 1908 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 √ F Iselin PA 222-22-9525 99 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 28a-f show must be notifled at 1 ☐ Yes 2 No ld Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or anager Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 27 No Yes, Give 'ear or Dates: 1 ☐ Never Married 2 ☐ Married 5 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 þ 3√ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 Is marked other the any injury or other traumatic event, the once. Art Teacher Newark School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Stella Depp James Moore ဂ္ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsay Thomas JR. Son Millersville, MD 21108 1176 Tanager Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2/20/2008 Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a.)Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner monwood Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence 4) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISEC Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient LIVING Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar

31. Date filed (Month, Day, FEB 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

,1684 Village Green Crofton Md21114

29c. License number

29d. Date signed (Month, Day, Year)

02-30

			1 _ State	epartment of Health and Men Certificate of Death	tal Hygiene Reg. No. 2008 07525
			Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death 3. Time of Death
	Physicia		Katherine J. Thrift	$\mid_{\mathbf{F}\epsilon}$	Porth Day Year 8:04 a.M
K.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	LAGIIIII	CI	Mallard Bay Care Center	Cambridge	Dorchester
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country)
U	Director		214-12-0780 91		ril 30, 1916 Maryland
	w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
`	Maryli f sho led at	ō	MD Dorchester	Cambridge	1 🖫Yes 2 ☐ No
)	the f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
}	h with		520 Glenburn Avenue	21613	USA
7	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 14. Race - American Indian, n, etc.) Black, White, etc.
9	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		1 Married 2 Married 1 Yes 2 Married If Yes. Give	1 ☐ Yes 2 ☑ No Specify:	Specify: white
8	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Decedent's Usual Occupation	16b. Kind of Business/Industry
7	n 72 "nat edic	Completed	(Specify only highest grade completed)	Give kind of work done during most of working life. DO NOT use retired)	Nind of Business/modsdy
112	withi iene. • than the M	E O	Elementary/Secondary (0-12) College (1-4or 5+) 1 1 4	pianist	music
b	filed II Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir	st, Middle, Maiden Surname)
<u>la</u> r	uld be Aenta rked ric ev	To B	James F. Thrift	Catherin	ne Dimsmore
Maryland 21215-0036	2 sho and I is ma		, , , ,	Mailing Address (Street and Number or Rural Ro	
	and ealth m 27			20 Glenburn Ave., Cambr	20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 Removal from State	y, crematory or other place)	•
Ë	t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) Salist 21. Signature of Funeral Service Licensee	oury Crematory 2/20/(22. Name and Address of Facility Thoma	_ ·
Bal	permit Depar Impor any ir		21. Signature of Purieral Service Licensee	700 Locust St., Cambr	
l.		Ý	23a. Part1. Enter the disease, or complications that caused the death. Do no		
100	Physician	l g	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	u Denerti	Onset and Death
	/Medical		disease or condition resulting in death) a		
ű	Examiner		Sequentially list conditions b.		
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Linet Urasmin, Cause (Disease or injury	f):	
	ecute and trans	Examine	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of the	rf)-	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	a E	, pac is for as a surissqueries	·/·	
687	icate phys s the	edical	d		
Box (eath certific attending p	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of delivery
	death a atte	icial	in the past 12 months? 1 Veg 2 No.	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
P.0	that the de red by the a	Physician/Med	9 ☐ Unknown		
	es the gned be de	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
or Vital Records,	w requires to been signer should be				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown
ec	e law I has be ge 2 sh	Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
E F		S			performed? death? 1 Yes 2 1 No 1 Yes 2 No
Vit.	Physician; Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of eath Cl	
	Phys r this ral di	<u>ا۔</u>	1 Tes 2 EH/Out	patient 3 DOA 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
9	Attending Part death. ector: After iby the funera	tion	1	njury Work? M 1 □ Yes 2 □ No	
Division	Attendir death.	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, far building, etc. (Specify)	m, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
	호를들도	Certification:			
	the Hospital hin 24 hours a the Funeral npletely filled		29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and	, death occurred at the time, date and place, and d/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
	thin 2,	Medical	one) and manner stated. 29b. Signature and title of certifor	29c. License number	29d. Date signed (Month, Day, Year)
\	Veitl Cor	-	Description and the or payment		2-18-08
•	1	ľ	30. Name and address of person who completed cause of death (item 23a) (D 47 7 24	
	\		1	Type, Print) ST CAMBRIDGE M	0 2/6/3
1		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0-5 - 4 - 52	
	Regist	rar	FFR 2 0 2008	to diameter	

ORIGINAL

		State of f FH G877 State of FH G877 Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of L	Jean	2. Date of De	ath		3. Time of Death
Physicia /Medic		LOIS JEAN TUCKER					Month 2	23 ^{Day}		1350 PM
Examin	er	4a. Facility Name (If not institution, give street and number ATLANTIC GENERAL HOSPITA			4b. City, Town, or BERLI	Location of Death			County of Death ORCESTER	
Funeral Director		5. Social Security Number 186-30-310 6. Sex 1 M 2 M F 7.	Age (In yrs. I	ast birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 4-4-19	th ay, Year) 36	9. Birthp Cour PENN	place (State or Foreign ntry) NSYLVANIA
Hilled within 72 hours after death with the Maryland Hilled within 12 hours after their insturati, or theme 23a or 28a-f show the their their heart realist Examinat must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation	-				10d. Inside City Limits
a-f sh	ctor	DELAWARE SUSSEX	SE	ELBYVII	LE					1 ☐ Yes 27 No
it of Health and Mental Hygiene. If item 27 is marked other then "netural", or iteme 23s or 28s-f show or other treumstic event, the Medical Examiner must be notified at	ai Director	10e. Street and Number 35581 SEAGULL ROAD			10f. Zip Code 19975			-	izen of What Cou	ntry?
ral', or iteme Examiner ma	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 1f Yes, Give Year or Date	s?		Vas Decedent of Hi Yes, specify Cuba □ Yes 21 No	spanic Origin? (Spin, Mexican, Puerto Specify;	ecify Yes or Ne Rican, etc.)	D-	14. Race - Americ Black, White, Specify: WH	
n "netui Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give life, L	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work.)	ing	16b. Ki	ind of Business/In	ndustry
adi.	Com	Elementary/Secondary (0-12) College (1-4) 5+	or 5+)	SCHOO	L TEACHE				JCATION	
ed oth	Be	17. Father's Name (First, Middle, Last) GEORGE MATTHEWS				18. Mother's Name			Sumame)	
umat	ဥ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rur	al Route Numb	er, City o	r Town, State, Zip	o Code)
lealth am 27 i		JOEL KUHARIK/ HUSBAND	20h B	A COLUMN TO A SECURITY OF	SEAGULL sition (Name of	RD, SELB	YVILLE			aum Ctata
Important: If its eny injury or ot once.		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Removal from Sta 4 □ Dopation 5 □ Other (Specify)	MET HEN	SOPEN	CREMATOR	θ) Y 2-25	-08	FRAN	NKFORD,	DELAWARE
eny ir		21. Signature of Funeral Service (Icom ea)			ERAL SERV R ST, FRA			LAWARE.	19945
		23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death h line.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
sician edical		disease or condition	as a consequence	c. S.	Jack .					
aminer		Sequentially list conditions, b.	Beps	and the same of th						
ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	de a consaqu	serice ory					- 1	
s the burial-transit	i Examin	resulting in death) Last Due to (or	as a consequ	uence of):					- 7/	
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should be deteched for use as	Physician/M		n 2.∏Fetal tat time of de	ideath 3□	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	rery Day Year
n signed b	by	Part II. Other significant conditions contributing to deat	h but not resi	ulting in the ur	nderlying cause give	en in Part I.		tobacco u		the cause of death?
2 8	Completed						24a. Was auto perf		prior to co death?	opsy findings available ompletion of cause of
certificete rector, pag	Be	25. Was case referred to medical examiner?			10#	26. Place of Deat	h (Check only	-		
After this (٦: <u>٦</u>	27. Manner of Death 28a. Date of I	Injury	ER/Outpatien 28b. Time of	t 3 DOA Oth	4 Nursing no	me 5 Res 28d. Describe		6 □Other (Specing occurred	fy)
tor: After	atio	2 Accident investigation	Day Year)	Injury		Yes 2 □ No				
of Direct	Certification:		Injury - At ho , etc. <i>(Specif</i>)		eet, factory, office		28f. Location City or To	(Street an own, State	nd Number or Rur a)	al Route Number,
within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page.	Medical ((Check only one) Cartifying Physician: To the basis and manner	s of examina	wledge death tion and/or inv	recurred at the tir. restigation, in my o	ia, date and place, pinion, death occur-	and due to the red at the time	causu(s) , date and	and mahner as a place, and due t	stated to the cause(s)
To the	Me	29b. Signature and title of certifier			29c. License	64120			te signed (Month,	
6		30. Name in address of person who completed cause	of death (Item	23a) (Type,	Print)	Berlin	MD		./23/08 1811	5
	- 18	Atif Zeeshon Aut 97:	33 Hc	with (1)	ay () nive	DC HIM)		or .	1011	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2008 7:50 p^M Taggart **February** 22 Patricia Ann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital 01ney If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months December 3, 1935 District of Columbia Director 72 578-44-8422 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County !/ Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 😿 No Director Maryland 01ney Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. 20832 U.S.A. 3909 Mt. Olney Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 IX If Yes, Give Year or Dates: 1 Never Married 2 x Married 2 🕱 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: if item 27 is marked other that any lijury or other traumatic event, the 1 once. Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marguerite Goode ဥ William C. Waters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Mt. Olney Lane, Olney, Maryland 20832 Basil Taggart - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 02/26/2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or part failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme in the Gruse (Final disease or condition resulting in death) CARDIOVASCULAR Physician +THEROSCIErotic YIEARS /Medical Due to (or as a consequence of): Examiner TRAL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 3 ☐ Probably 1 ☐ Yes 2 ☐ No Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1□ Yes 2 **N**o Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 atural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRO OLNEY, MARYLAND 20832 8/01 HERRING PRINCE Registrar's Signature Day 2 Year)

State

Registrar

2008

		1 - For State Registrar 1. Decedent's Name (First, Middle, L.			ertificate of	Death		Reg. No.	JUÖ	0 7 5 2 8
Physic /Med	ical	GERALD	TAY	LOR			Month FEBRUA	RY 19		
Exami	ner	4a. Facility Name (If not institution, gi				or Location of Death			inty of Death	
		THE MILLENNIUM Co. Social Security Number 6.		LLE (In yrs. last birthday	FOREST		9 Date of Bid	PRI	NCE GE	
-uneral Director			1☐M 2☐F 55		Months Days		8. Date of Birl (Month, Da JUNE	1952	VIR	place (State or Foreigr ntry) GINIA
4		10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
avant, the Medical Examiner must be notified at	ţ	MD PRINCE	GEORGE'S	CA	PITAL HE	IGHTS				1 ☐ Yes 2 ☐ No
e no	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
7	aic	5812 JUNIPERTRE	E LANE		20743			USA		
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	1	Race - Americ Black, White, ecity: BL	etc.
	ted	15. Decedent's E (Specify only highest gi	Education	16a. Dece	edent's Usual Occu	pation		16b. Kind o	f Business/In	dustry
	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	-)		pation during most of working d)				
	ပိ		2 YRS	INF	ORMATION	TECHNOLOG			VATE	
	Be	17. Father's Name (First, Middle, Las				18. Mother's Name			name)	
	2	GEORGE TAYLOR	(Time Brief)	46		GLADY				
		19a. Informant's Name/Relationship SHAYLA TAYLOR/		7226	: Co	and Number or Rura OURT HYATT				
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Disponentery, cre	osition (Name of ematory or other pla	ice)	ate	20c. Location	on - City or To	own, State
		4 Donation 5 Other (Special	(y)	1		TERY 2/25/			L,MARYI	
	١.	21. Signature Funeral Service Lice	nsee	2	2. Name and Addre	ess of Facility J	. B. JE	NKINS	FUNERA	AL HOME
		/1/un 5/1	lama			OOVER ROAD			RYLAND	20785
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused to one cause on each line	the death. Do not en e.	ter the mode of dyi	ng, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between
		Immediate Cause (Final disease or condition	CA1	RDIPULMUNA	ARY FAILU	RE			- 1	Onset and Death
		resulting in death)		consequence of):						
		Sequentially list conditions b. CARDIOMYOPATHY b. Due to (or as a consequence of):								
	iner	Faquentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			DEDI DION	AGE				
	Examin	that initiated events resulting in death) Last	U	RONARY ART	TERY DISE	ASE				
	= E			PERTENSION	J					
	edicai		_ d	LKILKBIO						
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnanc	у			Date of delive Month	ery Day Year
	Phy	9 Unknown							-	
	Ď	Part II. Other significant conditions			inderlying cause giv	ven in Part I.				ne cause of death?
	ted	CONGESTIVE H	CART FAILUR	Ľ			1 🗆 Y	′es 2□No	3 ☐ Prob	abiy 4 🕅 Unknown
	Completed						24a. Was a autop perfor	med?	b. Were autop prior to cor death? 1 \(\subseteq Yes	psy findings available appletion of cause of
	Be	25. Was case referred to medical				26. Place of Death	1 ☐ Yes Check only or		163	- M 140
1	70	examiner? 1 ☐ Yes 2 ☐ XNo	Hospital: 1 Inpatient	t 2 ER/Outpatier	nt 3 DOA Ot		18		Other (Specifi	v)
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Inju		8d. Describe h			
	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, sti (Specify)			8f. Location (S City or Tow	Street and Nu n, State)	mber or Rura	l Route Number,
	Medicai C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of miner: On the basis of eand manner state	examination and/or in	h occurred at the til vestigation, in my o	me, date and place, a ppinion, death occurre	and due to the co	ause(s) and date and plac	manner as st	ated. the cause(s)
	Me	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date sig	ned (Month, I	Day, Year)
		19mm/)		D515	20]	FEBRUA	RY 21,	2008
		30. Name and address of person who BAHRAM PISHDA	AD M.D. 132	8 SOUTHERN		S.E. WASHI	INGTON,	DC 20	032	
	ate	31. Date filed (Month, Day, Year) FFR 2 6 2008	32. Registrar	s Signatur	,					
	rar 001	FEB 2 6 2008	Seem A	7						

DHMH 17 Rev 1/2001

			1 - State of Ma		ertment of Health and I tificate of Death	Mental Hygie Reg.	2000	07529
	Physici	an	Decedent's Name (First, Middle, Last)	-		2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		James Tillman			Feb. 16,	2008	1336 ^M
	Examir	er	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital (lenter	4b. City, Town, or Location of Death Cheverly		4c. County of Deat Prince Ge	
	✓ Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign
	Director		245-50-5288 1 ¹ X ^M ² F	70 Yrs.	Months Days Hours Min.	Aug. 28,	1937	N. C.
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	e-fsh	ctor	D. C.	Washingto	n			1 X Yes 2 ☐ No
	vith th	Dire	10e. Street and Number	"	10f. Zip Code		Citizen of What Co	untry?
	leath v	erai	912 Eastern Avenue, N.E. 11. Marital Status 12. Was Decedent E	#03	20019 Vas Decedent of Hispanic Origin? (S		S. A.	ocan Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itame 23a or 28e-1 show say injury or other traumatic event, the Medical Exatrating caust be published.	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	o It	Yes, specify Cuban, Mexican, Puert Yes 2x No Specify:	o Rican, etc.)	Black, White	e, etc.
5-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupation kind of work done during most of wor	king 16t	. Kind of Business/	Industry
121	within ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5-12th	+)	OO NOT use retired) urity Guard	D D	. C. Gove	ernment
	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai		
ylar	Menta Menta arked atic sv	To B	Robert Tillman		Mary B	ell McNair		
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin 912	g Address (Street and Number or Ru Eastern Avenue,	ıral Route Number, Ci N.E∦03	ity or Town, State, 2	(ip Code)
	Healt Healt tem 2		Sabrina Tillman (Daughter 20a. Method of Disposition	20b. Place of Dispos	sition (Name of		. Location - City or	
altimore,	Pages lent of nt: if i		1 ☐ Burial 2 【MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ke Crematory 02	/23/2008	Beltsvil	
Balti	permit. Departrimporta		21. Signature of Funeral Service Licensee	00011	Name and Address of Facility H. Bacon Funer 3447 14th S	al Home, I	nc	20010
*53			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not ente	or the mode of dying, such as cardiac	or respiratory arrest,	. Washing	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	pople 9	nephalones	Ty		Onset and Death
	/Medical Examiner		Due to (or as	consequence of):	1. 1.			hou
*		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a	consequence (i):	ic gurk			<i>p.</i>
	and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a	rosperate	oy failure			
,60	licate be executed physicien and s the burial-transit	a E	Due to (or as a	consequence of):	ochonica			
68760	ifficate g phys as the	edical	d		7011000			
Вох	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months? 1 □ Live birth 2		Ectopic pregnancy		23d. Date of deli	,
	The law requires thet the death certif te has been signed by the attending page 2 should be detached for use a	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown		Other (specify)		Month	Day Year
P.0	thet the	y Ph	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Vital Records,	equires		Mercinsco	ጉ		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
eco	law re las be	Completed	Diobetes			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>=</u>		5				performed 1 ☐ Yes 2 🔯	l? death?	
Ĭ	siciar	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: Managina		Other	th (Check only one)		
o o	ding Phys th. : After this of funeral direction	n; To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury at Work?	ome 5 Residence 28d. Describe how it		cify)
Sio	Attending Physician: r death. sctor: After this certifica by the funeral director, I	atlo	2 Accident investigation	Year) Injury	M 1 Yes 2 No			
Division of	To the Hospitel or Attenwithin 24 hours after deation to the Funerel Director: completely filled in by the	Certification;	4 Homicide building, etc.			28f. Location (Street City or Town, St	tate)	
	To the Hospitel or within 24 hours afte To the Funarel Dir. completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	examination and/or invi	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To t Withi	Σ	29b. Signature and title of certifier	, , ,	29c. License number	29d.	Date signed (Monti	n. Day, Year)
	(2)		John A. ON	eus ML	V 7 3 3 4	l t	evrion	- 16, 2008
	5		30. Name and address of person who completed cause of dea	Prin	re George An	spilal	Cherie	ely, MR
386	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	Je no	7.12		(1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** $_{\rm P}^{\rm M}$ Sue Twigg 13, Norma February 2008 19:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖸 F Yrs 85 Director 216-14-1429 05/19/1922 Marvland Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 MYes 2 □ No be notified Director Allegany Cumberland the 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number with ō 701 E. 4th Street, Apt 115 or items 23a death v must USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ı "natural", or items ledical Examiner n Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. filed within Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Albert Heavner Bessie Hyre 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd H. Twigg / Son 121 Woodlawn Avenue, Bedford, PA 15522 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sunset Memorial Park 02/18/2008 Cumberland, MD 21. Sign rure of Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction Days /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner physician and the burial-transit executed Years Atherosclerosis Due to (or as a consequence of) P.O. Box 68760, that the death certificate be Physician/Medical as attending IF FEMALE use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Seizure Disorder, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed?

1 Yes 2 No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director; A investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completely f Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 February 15, 2008 D0054411 5

Registrar

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State

31. Date filed (FEB1 5 2008

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30. Na and address of veryon who completed cause of death (Item 23a) (Ty. Tint)
Beverly Calkins, M.D., 500 Memorial Avenue, Cumberland, MD

37 Registrar's Signature

08-01477

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Harry Gilbert Ulrich 2008 07531 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 20, 2008 1237 hrs Medical Examiner HARRY G. ULRICH 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia 10232 Hickory Ridge Road g. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreigNASHINGTON, Months Days Hours Director 10/17/1953 54 218-56-4607 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County BURTONSVILLE 1 X Yes 2 No HOWARD MARYLAND notified at once. with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20866 ā 14425 BURSLEN TERRACE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death Armed Forces' 2 X Married Never Married 2 X No Yes WHITE Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", o or other traumatic event, the <u>Medical Examiner</u> n Yes 2 X No specify: If Yes. Give Year Snecify: Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRICAL ELECTRICIAN 21215-0036 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) SELMA GOLDBURG STANLEY ULRICH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 14425 BURSLEN TERRACE, BURTONSVILLE, MD PAULA L. ULRICH-WIFE 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State JUDEAN MEMORIAL GDNS D2/24/2008 OLNEY, MARYLAND Donation 5 Other Specify 21. Signature of Francial Service Licensee 22. Name and Address of Facilit DANZANSKY-GOLBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MA ARYLAND 20852 Approximate Interval Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hanging Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760 23d, Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ð Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy death? performed? page ✓ Yes 2 1 🗸 Yes 2 No within 24 hours after death.
To the Funeral Dissert. 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject hanged self FOUND: Natural Yes 2 V No Pending Feb 20, 2008 1220 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 10232 Hickory Ridge Road, Columbia, MD determined (Specify) Single Family 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 21, 2008 O.C.M.E. Incontino. Norma IVI 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 31. Date filed Houth Day (ear) Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Uhl Angela Alberta 7 13, 2008 4c. County of Death February 2008 9:05 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany 1230 Vocke Road LaVale If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 👿 F 83 Director 211-12-9591 06/07/1924 Pennsylvania Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD LaVale Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 1230 Vocke Road r than "natural", or items 23a the Medical Examiner must b Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: δ 3 Widowed 4 □ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Automobile Dealership permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garfield William Bittner Blank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Gregory Uhl / Son 35 Johns Lane, LaVale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Vet Cem @ Rocky Gap 02/19/2008 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Jun ture of Funeral Service Licenter 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SYN BRUME **Physician** fort i were SEPSIS /Medical Due to (or as a consequence of): Examiner PARKINGUNKEN Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ o Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ◆ Unknown DEMENTIN Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1∐ Yes 2 MPNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending within 24 hours at To the Funeral D

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Registrar

Medical

Harjit 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

FEB 1 5 2008

29a. Certifier (Check only one)

> Sidhu, M.D., S. 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D26907

925 Bishop Walsh Drive, Cumberland, MD

29d. Date signed (Month, Day, Year)

February 13, 2008

				Please Type or Print in amend items 27, 28a State of Mary	n Black In	ndelible ink me g878 4	Ensure Al	I Copies	Are Legible.	
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-22		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examine: must be notified at once.	ō	VA Accomack	C. City, Town or L)				10d. Inside City Limits 1 XYes 2 □ No
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fle	5-0036	ours a iral', o	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: \	Uhite
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		Voint Con	_	29b. Signature and title of certifier					9d. Date signed (Mont	
	3	HAM		30. Nake and address of person who completed cause of death	(Item 23a) (Type	, Print)	J - 17/		OSICIATITY	19,2008 ALISBURY, Md.
	9	110		ANDY PIERRE M.D. I CHRI	Signature	SNYDER	20. 10	OE Care	ear St. S	ALISBURY, Md.
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	/Medic		Victoria M. VanEx				45 035	T	Landa 6		ebruary		, 2008 ounty of Death	3:30 A M
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, C			Holy Cross Rehab. 5. Social Security Number 6. Se			st birthday)		r 1 Year	If Under 24		Date of Birth		ontgome 9. Birth	place (State or Foreign
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•	Ψ		30. Name and address of person who o	completed cause of de	eath (Item :	23a) (Type,	Print)		- 13			~ /	,,,,,,,	3
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18	Sta		31. Date filed (Month, Day, Year) FEB 2 5 2	32. Pogistra	r's Signatu	erie	1 4		, 1	,	1		9	/)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7535 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Beverly Susan Wenk February 20, 2008 13:37P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Prince Georges Southern Maryland Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Days Hours Months 220-66-8651 53 Yrs. Director August 13,1954 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 4549 Dalles Place USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 🖔 No White ۵ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norrine Wedding Marvin Wenk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Hindle/Cousin 14563 Eastman St. Dale City, VA 22193 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem.2/29/08 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee AREHART-ECHOLS" FUNERAL HOME, P.A. M00945 an St. Mary's Ave. La Plata, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **M** No 1∐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗚 Ño 1 Dhpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Registrar

31. Date filed (Month, Day, Year) 2008 FEB 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0063698

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 2008 **Physician** Feb. 22, Felix Tak Cheung Wong 8:00 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5013 Aspen Hill Road Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 60 Jan. 15, 1948 China 578-76-3766 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Montgomery Rockville Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5013 Aspen Hill Road 20853 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Self Employed Acupuncture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Dong Wong Lem Chung Mei 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 Aspen Hill Road, Rockville, Maryland 20853 Ha Xu To/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/24/2008 | Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 years disease or condition resulting in death) a <u>Recurrent Nasopharyngeal Cancer</u> /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred Injury at Work? 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director; villed in by the f 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb. 22, 2008 D 33109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 Reservoir Road, NW., Washington, DC 20007 Jimmy Hwang, MD., 31. Date filed (Month, Day, Year) FEB 2 5 2008 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20, 2008 **Physician** Wilson 7:06A. George D. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) **Examiner** 11360 Cherry Hill Road,#302 Beltsville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 7, 1938 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 227-46-0574 1**X** M 2□ F 70 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at Maryland 1 ☐ Yes 2 ▼No Prince George's Beltsville Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

In mortcant; If item 27 is marked other than "natural", or items 23a or any fillury or other traumatic event, the Medical Examiner must be rangely in Jury or other traumatic event, the Medical Examiner must be range. 11360 Cherry Hill Road, #302 20705 United States 12. Was Decedent Ever in U.S. Agged Forces? 1 Kayes 2 □ No If Yes, Give Year or Dates: 1957–1965 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 9 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Assistant Applied Physics Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reynolds Wilson Charlene Anderson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wiltrude D. Wilson -wife 11360 Cherry Hill Rd.,#302 Beltsville, Maryland20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2/21/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Lic Bonald ViesBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease **Physician** vears /Medical Due to (or as a consequence of): Examiner Essential Hypertension vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Obesity burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician certificate be Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Vear 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Diabetes Mellitus type II; Hyperlipidemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No certificate ha death? 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation ual or Ath.

ours after death.

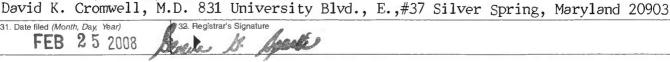
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in by the fire Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D03835 February 20, 2008 owner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

2 5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LENO ,22"200 DUIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept. 24, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1 M 2 ☐ F 579-14-7273 1918 Georgia Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 → No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 USA 6605 Allview Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 A Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Media Specialist Education 12 should be filed w h and Mental Hygier 7 Is marked other tt permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olga A. Crane Edward Lee Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6605 Allview Drive, Columbia, MD 21046 19a. Informant's Name/Relationship (Type. Print) Faustine Wilson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 23, Feb. 1 ☐ Burial 2 X & remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licensee Francis Address & Familians Funeral Home Inc. John Kyle C Mary 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** /Medical Due to (or as a consequence of): Examiner diopalhic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner Dague certificate be executed burial-transit physician Box 68760 Physician/Medical ass IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho certificate has autopsy 1□ Yes 2 No Division or Vital e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 I Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the date and place, and due to the cause(s) and manner stated. (Check only one) To the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH GEH, NB 300 ARNORY PL, SVITE 39 BALTIMORE ND 21201

3 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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Funeral		5. Social Security Number	ô. Sex	7. Age (In yrs. ia	st birthday)	If Under 1 Months	_	nder 24Hrs.	1		. Birthplace (State or Foreign Country)
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	[21. Signature of Funeral Service	Licensee							s runera. ington, l	Home, Inc.
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Box 68760, e death certificate be the attending physic ed for use as the bur	icia	past 12 months?		gnant at time of de	eath 5	Other (Specif	fy)			1	4
D. Box 68760, at the death certificate be exceed by the attending physician ached for use as the burial-	Phys	Part II. Other significant condit	1	nown	esulting in th	e underlying o	ause given	in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	by	Fait ii. Other significant condi-	iona contributing	10 000111 00111011	000,4.1.9 4				1Yes	s 2 V No 3	Probably 4 Unknown
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COFC law re has be	nple									rmed? de	eath?
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Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpati		Otho		ig Home 5	Residence 6	Other: Scene
Division of Vital Records, rid or Attending Physician: The law requiring Physician: The law requiring a birectorary. After this certificate has been sided in by the funeral director, page 2 should be in by the funeral director, page 2 should be a busine and a busine bases.	. To	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Time	of Injury 28	Bc. Injury at			how injury occurre struck by auto	
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ivisior or Attend after death Director:	ii:		stigation 28e. Pl	ace of Injury - At h	nome, farm, s	treet, factory,	office buildi		or Town	State)	r or Rural Route Number, City
Di pital ours a eral I	Ser	4 Homicide		y) Major Roa					-		210 @ Pine Dr., Accokeek,
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b	est of my knowled	dge, death or and/or invest	curred at the tigation, in my	time, date a opinion, dea	nd place, and ath occurred a	I due to the cau at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
To th comp	Medical		and manne	r stated.			License nu				d (Month, Day, Year)
9/2	2	29b. Signature and title of certific					O.C.M.E			February 17	
		30. Name and address of person	who completed a	ause of death /Ites	m 23a)						
			sistant Medica		111 Pen	n Street, B	altimore,	MD 2120	1		
s	tate	31. Date filed (Month, Pan Sear)	Seren 32.	Regionar's Si	and I						
Regis	strai	FED % - Cook	June	- "/							

			For State	State of Ma	aryland /		tment of ficate of		Mental Hy	/gien Reg. N	- Z H H R	07540
		4.	Registrar Decedent's Name (First, Midd	fle, Last)					2. Date of D Month	eath		3. Time of Death
	Physici /Medic		Jessie L	William	son				Februa	ry 1	4, 2008	3:20 P M
	Examin	er	4a. Facility Name (If not institution Clinton Nursing			4	b. City, Town, Clinto	or Location of Dea	ath		c. County of Death Prince Ge	
e sede	Funeral	200 %1	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last t		If Under 1 Year	If Under 24 Hi	s. 8. Date of B	irth	0 Rinth	place (State or Foreign
	Director		579-70-5075	1□M 2XIF 8	4	Yrs.	Months Days	Hours Mi	June 2	8, 1	923 Nort	h Carolina
	land bw t		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, To	wn or Loca	tion					10d. Inside City Limits
	Mary a-f sho	tor	MD Princ	e George's	Temp	le Hi	.11s					1 ☐ Yes 2 No
	or 28;	Director	10e. Street and Number				10f. Zip Code				Citizen of What Cou	ntry?
	eath w		3402 Rickey Av	12 Was Decedant	Ever in II S	12 Wa	20748	Hienanic Origin?	(Specify Ves or N	USA	14. Race - Ameri	can Indian
36	be filed within 72 hours after death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ※ Widowed 4 □ Divorce	Armed Forces? rried 1 ☐ Yes 2 ☑ If Yes. Give	No		es, specify Cul	Hispanic Origin? ban, Mexican, Puo Specify:	erto Rican, etc.)	O ^z	Black, White,	
215-0036	2 hour atural cal Ex			ent's Education est grade completed)	16	a. Deceder	nt's Usual Occu	ipation		16b.	Kind of Business/Ir	
212	within 7; iene. than "n: the Medi	Completed	(Specify only high Elementary/Secondary (0-12)	College (1-4or 5	5+)			e during most of weed)	rorking		Laur AME C	1 1.
121	filed wi Hygier Sther th	S	17. Father's Name (First, Middle	2 yrs.	L	ay Ca	re Dir	T	ame (First, Middl		len AME C	nurch
and	ild be f fental l rked of	To Be	Jesse Richards	•					Austin	o, maid	in Garriano)	
Mary	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relation			9b. Mailing	Address (Stree	t and Number or	Rural Route Num	ber, City	or Town, State, Zi	p Code)
	l and lealth		Sylvia A. Will	iamson/Daugh.			Rickey A	Avenue	Temple H		-	748
galtimore,	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (ceme	tery, crema	tory or other pla Cemeter		25-2008		Location - City or T cham, NC	own, State
altil	mit. P partme portan / Injur.		21. Signature Funeral Service		/			-			Funeral H	ome, Inc.
ă	and Dec		D 4.19 711	arshall		42	217 9th	Street,	NW Was	hing	gton, DC	20011
			23a. Part1 The the disease, of shock, or heart failure. Lis	_		o not enter	the mode of dy	ring, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Demen Due to (or as	tia a consequenc	e of).						
	Examiner		On the Park of the	h but to (or as	a consequenc	c oi).						
	sit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	e of):						
_In	ificate be executed g physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequenc	e of):						
08/00	te be e ysiciar ne buri	edical E		d								
_		Medi	IF FEMALE:									
ž	death certiff e attending ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea		ctopic pregnan				23d. Date of deliv Month	very Day Year
j.	that the deed by the detached	hysi	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9□Unknown	t time of douti	000	inor (opcony)					
<u>ري</u>	w requires that the de been signed by the s should be detached	by P	Part II. Other significant condit	•	ut not resulting	in the unde	erlying cause g	iven in Part I.				the cause of death?
ecords,	requires seen sign hould be		Chronic Renal	Disease								bably 4 Unknown
S L	e la has je 2	Completed							24a. Wa auto per	s an opsy formed?	f prior to co	opsy findings available ompletion of cause of
VITA! H	ilcian: Th certificate ector, pag	a)	25. Was case referred to medic	al				26. Place of D	1 Yes eath (Check only		No 1 ☐ Yes	2 No
	hyslci his cer I direc	To B	examiner? 1 ☐ Yes 2 🂢 No		ent 2□ER/0	Outpatient	3 DOA	ther: 4 🕅 Nursing			6 □Other (Speci	ify)
0 00	ling P	ion:	27. Manner of Death 1 X Natural 5 ☐ Pendi		iry 28b iy Year)	. Time of Injury	28c. Inji Wo	ury at ork?]Yes 2∐No	28d. Describe	how inj	jury occurred	
VISION	Attency death	Certification:	3 Suicide 6 Could	mined Zoe. Place of Inj	ury - At home,	farm, stree					and Number or Rur	ral Route Number,
5	tal or safter al Dire	Serti	4 ☐ Homicide deten	building, et	c. (Specify)				City or To	own, Sta	ite)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical application is a second of the funeral director.	Medical (29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best at Examiner: On the basis of and manner st	of examination a	ge, death o and/or inve	ccurred at the stigation, in my	time, date and pla opinion, death or	ce, and due to the courred at the time	e cause e, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Complete	Me	29b. Signature and title of certifi	\sim			29c. Licer	se number		29d. D	ate signed (Month)	, Day, Year)
	(6)		▶ Wellin	6 Cemen	5 MD		D35	206		Feb	ruary 15	, 2008
	Caro		30. Name and address of person William T. Tan	·				101 Ft.	Washinot	on.	MD 2074	4
	Sta	te	31. Date filed (Month, Day, Year FEB 2 1 2008		ar's Signature	•				,	2014	
	Registr	ar	FFRZ 1 7000	Man X	ALCON !	5.0						

			For State Registrar	ate of Maryland	-	artment of H ctificate of L		-	100 0	108	07541
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	V 100 100	3. Time of Death
	Physicia		Marry Magdalone	Whiteman				Month Februs	ry 17,	Year 2008	0235 ^M
	/Medic Examin		Mary Magdalene 4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Deat			y of Death	
Ž.	Examini	iei	Prince George's Hos			Cheverl	v		Prin	ice G	eorge's
w	Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs			9. Birth	place (State or Foreign
	Director		127-44-6767 1□M 2	21XF 93	Yrs.	Months Days	Hours Min.	Oct 2	2, 1914		intry)
9	-		Usual Residence of Decedent					000. 2	., .,.,	OTCIL	
	ylan ylan		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. inside City Limits
	Mar a-f st	į	Maryland Prince Geo	roe's Hvat	tsvil	1e					1 Yes 2 No
	r 28	Director	10e. Street and Number	,		10f. Zip Code			10g. Citizen of	What Cou	intry?
	h with		4837 - 66th Avenue			20784			Grenad	la	
	be filed within 72 hours after death with the Marylar tal Hygiene. ed other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	specify Yes or No			can Indian,
٥	after or ite	교	1 ☐ Never Married 2 ☐ Married 1	☐ Yes 2 No Yes, Give		_	Specify:	to rican, etc.)		ick, White	_
9500-612	al",c	by	3 😾 Widowed 4 □ Divorced "Ye	ear or Dates:		I∐Yes 2∏X No	эресну.		Speci	<i>ту:</i> В.	lack
၃	72 hc natur lical	Completed	15. Decedent's Education (Specify only highest grade com	nleted)	16a. Deced	lent's Usual Occupa	ation Juring most of wo	rkina	16b. Kind of E	Business/Ir	ndustry
Z	thin e.	鱼		ollege (1-4or 5+)	life. L	kind of work done of OO NOT use retired)	ining			
7	d wil	9	8 years		Sea	mstress			Self	Emp	loyed
9	al Hy oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ne (First, Middle	, Maiden Surna	me)	
/land	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at	To	Joseph Hypolite				Wilh	emina Mo	Millan		
a _Z	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injuy or other traumatic event, the Moce.		19a. Informant's Name/Relationship (Type. Page 1997)	rint)		ig Address (Street a					'
Ma	and 2 alth :		Patricia B. Whitema			37 – 66t1		Hyattsv	ville, M	1D 20	784
заптоге ,	of He		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location	- City or T	own, State
Ĕ	Page lent c nt: If ry or		1 Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Øther (Specify)	al from State		metery	1	h 6, 20	08 St. A	ndre	w's, Grenada
	mit.		21. Signatury of Funeral Source Now see	/ 10200		. Name and Addres					
ñ	permi Depar Impor any ir		In 3 Hours	1		001 Benni					
	-		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cal	ns that caused the death.			-		-	· T	Approximate
			Investigate Course (Final							- 1	Interval Between Onset and Death
,	Physician / /Medical		disease or condition	Intracerebra		norrnage					3 weeks
	Examiner.			Due to (or as a conseque							2 Months
		<u>-</u>	Sequentially list conditions, b.	Uncontrolled		ercension				-	2 FIOREITS
	ed	Examiner	Sequentially list conditions, if any, leading to financial to cause. Enter Underlying Cause (Disease or injury that initiated events c	Dao to (or as a concodas	1100 01).						
	ecut and Ftrar	xan	that initiated events c	Due to (or as a conseque	nce of):						
8/00,	be ey cian buria	E		240 10 (0) 40 4 001100440	.,,,						
Ø	icate be executed physician and s the burial-transit	dical	d								
o X	ertiffi ling p	CO	IF FEMALE:								
o n	death certifi e attending d for use as	sician/M	in the nest 12 months?	yes, outcome pf pregnand □Live birth 2□ Fetal d	leath 3	Ectopic pregnancy				ate of deliv Ionth	very Day Year
	the de y the a iched f	sic	1 T Vac 2 X No 4	□Pregnant at time of dea □Unknown	ith 5∟	Other (specify)					,
Ţ.	w requires that the death certifi been signed by the attending I should be detached for use as	Phy		ing to dooth but not reculti	ing in the u	adarlylag gayaa giya	on in Bort I	220 Did	tobagge upo gor	atributa to	the cause of death?
<u>v</u> î	requires that een signed b nould be deta	β	Part II. Other significant conditions contribut	ing to death but not result	ing in the u	idenying cause give	mmran,				
2	equii sen s ould	ted						''	Tes ZLANO	3 Pro	bably 4 □Unknown
Records	law r as be 2 sh	ble						24a. Was		. Were aut	opsy findings available ompletion of cause of
	ician: The lav certificate has rector, page 2:	Completed						perfe 1□ Yes	ormed? 2⊠No	death?	2 No
VItal	ian: rtiffica stor, p	as .	25. Was case referred to medical				26. Place of De	ath (Check only			
		OB	examiner? 1 ☐ Yes 2 ☑ No Hospit	al: 1-√∑ Inpatient 2 □ EF	R/Outpatien	t 3 DOA Othe	er: 4 Nursing I	Home 5 ☐ Res	idence 6 □OI	her (Spec	ify)
0		n: T		a. Date of Injury (Month, Day Year)	8b. Time of	28c. Injun Work	/ at	28d. Describe	how injury occu	rred	
0	Attending r death. ector: After by the fune	ațio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Buy Your)	,,		Yes 2 □ No				
UNISION	Atte	iţi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28	e. Place of injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office			Street and Num wn, State)	ber or Ru	ral Route Number,
5	al or	Certification:	T	building, etc. (epochy)				Oily or 10	m, olalo,		
	ospit hours inera y fille		29a. Certifier 1 Certifying Physician								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: 0 one)	and manner stated.	m and/or in	vestigation, in my o	pirilon, death occ	urred at the time	, date and place	, and due	to the cause(s)
	To the within 2 To the Complet	ž	29b. Signature and title of certifier	1	110	29c. License		3	29d. Date sign		
	11-		- Jashul 1	mull.	NIL	Do	058	2/3	2-1	19-0	8
0	(3)		30. Name and address of person who complet	ted cause of death (Item 2	23a) (Type,	Print)					
_			Farhad Jamaui, MD 7	525 Greenway	y Cent	er Drive	Greenbe	1t, MD :	20770		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re						
	Registr		FEB 2 1 ZUUS Bleen	w No Appe							

State of Maryland / Department of Health and Mental Hygiene 07542 Certificate of Death Reg. No... 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Ernestine Gloria 02 15 08 0120 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 K) F 79 Director 213-24-6422 02/28/1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Intent of Heath and Mental Hygiene. The wast. If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 TYes 2 □ No Director Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 USA 316 Cumberland Street, Apt 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: à White 3 ☐ Widowed 4 🂢 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Snider George Hilda Mitchell Amy ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David L. Wills / Son permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troonce. 817 East Elm Street, Missouri Valley, Iowa 51555 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Cumberland Crematory 02/16/2008 4 □ Donation 5 □ Other (Specify) Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Physician HEART /Medical Due to (or as a consequence of): Examiner CORDITALLY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ OR TRUETIVE 1 ☐ Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HY/ENTENSION 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 19—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Cumberland Walsh Road Sidhu MD 30. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day MARVIN VOLING FEBRUARY 15 2008 13:13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death PRINCE GEORGE'S BOWIE HEALTH CENTER BOWIE 5. Social Security Number 251-56-2892 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/15/1936 Birthplace (State or Foreign Country)
 PA **Funeral** 1**X** M 2□ F Director Yrs Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits or 28s-f show the Medical Examiner trust be notified at 1 ☐Yes 2 ☐ No Directo MDPRINCE GEOEGE'S RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 5322 67th AVENUE 20737 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No BLACK þ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) CABINET MAKER 4th PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be and Mental I CARRIE BUTLER FRED **JERRIDO** ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l DAISY YOUNG/WIFE 5322 67TH AVENUE RIVERDALE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of P Importent: If its any Injury or of ance. 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 2/22/2008 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or ophplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Heart Disease /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit The taw requires that the death certificate be executed Exam Diabetes Mellitus Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Respiratory Failure use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 has autopsy performed? certificate 2 No Division of Vital 1 ☐ Yes 2 ☑ No Attending Physicien: director. 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sther (Specify) ROWLE CNT Hospital: Certification: To 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury after death.
I Director: Af in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide ŏ Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical P. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 18, 2008 D45217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 6201 GREENBELT ROAD COLLEGE PARK, MARYLAND 20740 4. AJAYI ADEBOWALE 31. Date filed (Month, Day Year) FEB 2 6 2008 32. Registrar's Signat State Registrar

			For State Registrar	State of Maryland /	-	rtment of H tificate of L			giene Reg. No.2	08	07544
1			Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Althea Young					Februar		008	8:40 A M
2	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of D	eath	4c. Count	y of Death	
		A _G	St. Thomas More N			Hyattsv If Under 1 Year		He Land (n)		ce Geo	
١.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Yrs.	Months Days		Min. (Month, Da	y, Year)	Counti	**
فيرية	Director		246-50-5450 Usual Residence of Decedent	73				Nov. 25	<u>, 1934</u>	North	<u>Carolina</u>
	/land		10a. State 10b. County	10c. City, Tov	vn or Lo	cation				10	d. Inside City Limits
	Man a-f sh ifled	tor	District of Colu	ımbia Wash	ning	ton					1 XYes 2 No
	th the or 28; e not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	th will		5459 Benning Road,	SE #104		20019-				d Sta	
	tems er m	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Ra Bla	ce - America ack, White, e	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	-	I□Yes 2☐No	Specify:		Speci	fy: B	lack
21215-0036	houn tural	q pa	15. Decedent's Educa	T	a. Deced	lent's Usual Occupa	ation		16b. Kind of E	Business/Indi	ustry
5	in 72 n "na Nedic	plet	(Specify only highest grade	completed)	(Give life. L	kind of work done of OO NOT use retired	furing most of)	working			,
7	with yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurse			Gover	nment	
ğ	e filed I Hygi other /ent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	, Maiden Surna	me)	
Jai	uld be Menta rked itic ev	TO E	Bruce Elmore Young	3			Mary	/ Elizabet	h Stric	kland	
Maryland	12 should be fill hand Mental H is marked oth raumatic even	Ė	19a. Informant's Name/Relationship (Type			•		or Rural Route Numb			
	and 2 ealth n 27		Althea Julian You					Rd Sprin			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State 20b. Place cemet	of Dispo ery, crer	sition (Name of natory or other plac	e)	Date	20c. Location	- City or Tov	wn, State
Ē	. Рас ment tant: jury с		4 □ Donation 5 □ Other (Specify)	Resur				≥ъ 20, 20¢			
gai	permit. Pag Department Important: I any injury c		21. Signature of Foneral Service Licenses	the Harper				Stewart F			
	40 = 60		- MIMIC INSC	alle I				ad, NE Was			
			23a. Part1. Enter the disease, or complic shisk, ir heart fallure. List only one Immediate Cause (Final	cause on each line.	- ^	4	g, such as ca	Total of respiratory a	1-		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con equence		OCCUrd	cal.	Intar	CT		
	Examiner			Post of her	01).	Vaca	1	15000	.6		
	er de la company	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a nsequence	e of):	Versu	HCLY	0,10013			
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.								
o,	execan an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequence	e of):						
8760,	cate be executed physician and the burial-transit	dical	d.								
9	entifica ing ph	Med	IF FEMALE:								.
Box	ath ce ttendi or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 		Ectopic pregnancy				ate of deliver	ry Day Year
	ie deg the al	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5	Other (specify)					,
<u>Р</u>	The law requires that the death certificate has been signed by the attending lange 2 should be detached for use as	Phy	Part II. Other significant conditions cont	ributing to death but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use coi	ntribute to th	e cause of death?
Records,	signe	Completed by	Sil Subtated	Calos farm	A	r I-SC	hemi	CP ph 10	Yes 2 No	3 ☐ Proba	ably 4 □Unknown
Ö	v requ	etec	200 - Cos	1 1 - U.A	0	troph	, ,	24a. Was	an 24h	Were autor	osy findings available
Ř	has ge 2	dm	perion pros	pour my	ev	1,084	y	auto	psy ormed?/	prior to con death?	npletion of cause of
	n: Th ficate or, pa		25. Was case referred to medical				00 Pi	1 Yes	2 N io	1 □ Yes	2□ No
Vita	sician: The law s certificate has b lirector, page 2 s	o Be	examiner?	ospital: 1 □ Inpatient 2 □ ER/C	utnatien	t 3DDOA Otho	· /	Death (Check only only only only only only only only		ther (Spacific	()
Ö	J Phy er this eral d	. To	27. Manner of Death	28a. Date of Injury 28b	. Time of				how injury occu		/
<u>o</u>	nding th.	ıtior	1	(Month, Day Year)	Injury		k? Yes 2 □ No				
Division or	l or Attend after death Director:	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (Street and Nun	nber or Rura	Route Number,
	tal or s afte al Dir ed in	Certification:	4 Intermede	ballang, etc. (opechy)				Only of 10			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physic	cian: To the best of my knowledger: On the basis of examination a	ge, deati and/or in	n occurred at the tir	ne, date and pointion, death	place, and due to the occurred at the time	cause(s) and r	manner as st e, and due to	ated. the cause(s)
	the hin 24 the F	Medical	one)	and manner stated.					29d. Date sign		
	To To	~	29b. Signature and title of certifier	vets 2. ml	2	29c. Licenso		524	, ,	1/00)
•	16		· /	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \) (T	I IVI I	1 0 10	7	0-11	4/01	5
0			30. Name and address of person who con	St. Though M		1/14- Hi	attan/	a ndi	,		
10	Sta	te	31. Date filed (Month Dev Year)	32. Registrar's Signature	1	1.40	1130111	u 1 vi			
			CCD 7 W ZUUO MA	distant of the second	_						

											jible.	
Alleg	gany Co.	02	/15/08, 1- State amend #7 Per Registrar	State of Mary FH G877 3/	/land / Depa 10/08 JH Ce/	artment o rtificate o	of Health a of Death	and M	ental Hyg	iene _{eg. No.} 2 (008	07545
- 6	Physicia	an	1. Decedent's Name (First, Middle, La						Date of Deat Month	th Day	Year	3. Time of Death
	/Medic		Viona B. Yutz						_1	19		9:25P M
	Examin	er	4a. Facility Name (If not institution, give				n, or Location	of Death			ty of Death	
		施。	Kline Hospic				Airy ear If Under	Od Hen	0.001.0001	Fr	eder	
	Funeral		5. Social Security Number 6. S	I M WEET	n yrs. last birthday) On Yrs.		ays Hours	Min.	Date of Birth (Month, Day,		9. Birthpi	
	Director		170-36-1223 Usual Residence of Decedent		83 Yrs.				2-28-1	924	<u> </u>	PA
	land ow at		10a. State 10b. County	10	c. City, Town or Lo	cation					10	d. Inside City Limits
	Mary Fish fied	tor	MD Frede:	rick	Adamst	own						1 Yes 2 No
	r 28a	ìrec	10e. Street and Number			10f. Zip Co	de		1	0g. Citizen of	f What Coun	try?
	h with	Funeral Director	3310 Paprika	Ct.		2171	10			USA	1	
	deat	ner	11, Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent	of Hispanic Or	rigin? (Spe	cify Yes or No- Rican, etc.)		ace - America	
9	after or Ite mine		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2 🔼			rican, etc.)		ack, White, 6	
33	ours ral", Exa	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:		1	Tto Opecny.			Spec	ity: Whit	е
5-6	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	dent's Usual O kind of work d	ccupation one during mos etired)	st of workir	ng I	16b. Kind of	Business/Ind	ustry
121	vithin ne. han '	m I	Elementary/Secondary (0-12)	College (1-4or 5+)						_		
2	Hygi her h, t	ပိ	17. Father's Name (First, Middle, Last)	Hom	emakeı		er's Name	(First, Middle, I		Home	
Baltimore, Maryland 21215-0036	2 should be f n and Mental H is marked of raumatic ever	Be	Lester L. Lini									
<u>Z</u>	hould d Me mark matic	은	19a. Informant's Name/Relationship		19h Mailir	na Address (St		<u> </u>	Elizab I Route Number			Codel
Ma	d2s than trau		Joan Wyrwa/ Da						boro,			0000)
á	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name o	of .			20c. Location		wn, State
ᅙ	ages ent of t: If if		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	cemetery, cree Mount H			1-23	-08	South	For	ь РА
量	artme ortan injur		21. Signature of Funeral Service Lice	1								Funeral
B	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evonce.	1.4	THOMAN IN	Atita					ce St.			
	A		23a. Part1. Enter the disease, or comshock or heart failure. List only	plications that caused the							Caman	Approximate Interval Between
	Physician	i y	Immediate Cause (Final						0.	198	1/40	Onset and Death
	/Medical		disease or condition resulting in death)	a. Subdur Due to (or as a co	al Hena	toma_		-	21	1 32	DWR	1 week
R	Examiner				agic Str	oke			W9.	1/20	\(\mathcal{P}\)	
2		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co				0	10 12	hi		
	xecuted and II-transit	xamine	that initiated events	C				Not	7	dil	1	
Ö,	g = e	Ш	resulting in death) Last	Due to (or as a co	onsequence of):			P)	ROV			
376	ate be nysici he bu	ical		d				()	MANN			
39	The law requires that the death certificate be e ale has been signed by the attending physician page 2 should be detached for use as the burra	Completed by Physician/Medical	IF FEMALE:					7	Hu			
9	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1□Live birth 2 □	Fetal death 3]Ectopic pregn		1			ate of delive	ry Day Year
0.	e deg	sici	1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregnant at tim 9□ Unknown	ne of death 5□	Other (specif	fy)			, ,	nonu.	Day Tour
9.	d by letach	Phy	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying caus	e civen in Part I		23e Did tol	nacco use co	ntribute to th	e cause of death?
S,	ires t signe I be c	by	_Atrial Fibulla	-	-		•	••	1 □ Ye			ably 4 □Unknown
Ö	w require been si should b	eted	_ACITAL FIDRITA	acion, mui	ripre 2	rokes	š					
ec	e law has b	nplo	hypertension						24a. Was a autops perforr	n 24b sy	 Were autor prior to cor death? 	osy findings available npletion of cause of
=	r: Th cate ; pag	S							1□ Yes	2 No	1 Yes	2□ No
Division or Vital Records, P.O. Box 68760	Attending Physician: The law r death. ctor. After this certificate has t by the funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Other:	_	(Check only on			HOSPILE
ō	Phys	2	1 X Yes ♣ → O	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4 LI NI		ne 5 Reside			House
on	ding J. After fune	ion	1 Natural 5 Pending 2 KAccident investigatio	(Month, Day Ye	ear) Injury		Injury at Work? 1 ☐ Yes 2 √x				uned	
S	deatl deatl ctor; y the	fical	3 ☐ Suicide 6 ☐ Could not b	e 290 Place of injune	Unk p - At home, farm, str				ubject fe	reet and Nun	nber or Rura	I Route Number,
<u>S</u>	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	•			310 Papri	n, State)		
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			nysician: To the best of n				ind place, a	and due to the c	ause(s) and i	manner as st	ated.
	n 24 h	Medical	(Check only 2 Medical Exa	miner: On the basis of ex and manner stated	amination and/or in I.	vestigation, in	my opinion, de	ath occurr	ed at the time, d	late and place	e, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	241.		29c. Li	cense number		2	9d. Date sign	ned (Month,	Day, Year)
	10		all the Cotto	oully N	1.77	D.3	35183		/	refra	uang	4,2008
	DK		30. Name and address of person who			Print)						/ /
_	かん			rookteh M.		West 9	th St	. Fr	ederic	k, MI	217	01
ė	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 2008	2. Registrar's	Signature	K)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Linda M. Ziemski 2008 tebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balt. Wash. Medical Center Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F 54 216-68-8112 11/15/1953 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County show at MD 1 Tiyes 2 TXNo Anne Arundel Pasadena other traumatic event, the Medical Examiner must be notified Director 28a-f s 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 8149 Solley Road 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 X Married 1 ⊟ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 'natural', or þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Construction, Plumbing 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John P. Muller Anna M. Blob 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai Mark Ziemski / Husband 8149 Solley Road., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory 02/22/2008 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Fuperal Service Licensee M01452 2818 E. Baltimore St., Baltimore, MD 21224 Approximate Interval Between Onset and Death 23a. Pak1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final hysician disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 HInknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner?
1 X Yes 2 No 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Dinpatient P 2 ER/Outpatient 3 DOA after death. 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours at To the Funeral C sompletely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 32 Registro

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

ches	ster B Zauch		State of Maryland / Department of Health and Menta 1- For State Certificate of Death Registrar	al Hygie	ene Reg. I	vo. 20	08 0754
	Physicia	an/	1. Decedent's Name (First, Middle,Last)		ate of Death onth Da ebruary 20,	ay Year	3. Time of Death 1808 hrs
viec	dical Exami		CHESTER B. ZAUCHA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		bruary 20,	4c. County of De	
H			Prince Georges Hospital Center Cheverly			Prince Geo	
	Funeral Director		5. Social Security Number 168-12-6734 6. Sex 7. Age (In yrs. last birthday) Nonths Days Hours	Min.	Date of Birth(N	Fo	Birthplace (State or reign Country) PA.
	ny A	+	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	daryland 28a-f show any d at once.	٦	MD. PRINCE GEORGES HYATTSVILLE				1 X Yes 2 No
	/aryla 28a-f 1 at on	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What C	Country?
	with the Maryland ns 23a or 28a-f sho be notified at once.		3506 57th AVE. 20784				.S.A.
		Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican,			14. Race - Ar White, et	merican Indian, Black, c.
	fter des		1 X Yes 2 No 3 X Widowed 4 Divorced If Yes Give Year WWII 1 Yes 2X No specify:			Specify:	WHITE
	ours al atural xamin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT usual Complete in the following most of working life. DO NOT usual Complete in the following most of working life. Do NOT usual Complete in the following most of working life.		done 16	b. Kind of Busine	ess/Industry
	36 in 72 h nan "n iical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)			D A MIZ	-
	215-0036 be filed within 72 hours after death with the Maryland that Hyggiene. Intel Hyggiene and "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once	Completed	12 LOAN OFFICER 17. Father's Name (First, Middle, Last) 18.Mother's		st, Middle, Mai	BANK den Surname)	
	21215-0036 yuld be filed within 72 hours after death Mental Hygiene. marked other than "natural", or ite re event, the Medical Examiner must	Be (STANLEY ZAUCHA	STE		SPLET	
	ond hou	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 19b. Mailing Address)				
	ges 1 and 2 shou to f Health and N t: If item 27 is n other traumatic		CAROLYN ZAUCHA/DAUGHTER 3506 57th AVE., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	HYAT Da		E, MD. 2 Oc. Location - Cit	
	ages 1 nt of H		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	FFR 2	6,2008	STLVE	R SPRING,MD.
	Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If iten 27 injury or other traum.		4 Donation 5 Other Specify: GATE OF HEAVEN CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERA				
		7 ()	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	AVE.,	RIVERI	DALE, MD	20737 Approximate Interval
	Physician /Medical		failure. List only one cause on each line.	irdiac or res	piratory arrest	, SHOCK, OF HEAR	Between Onset and Death
1	-xaminer		Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):				
			Sequentially list conditions, b.				
		nine	if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated Closease or injury that initiated				
6	ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
•	60, ate be executed hysician and e burial - transit	Medical	d. UNPENDED AMENDED				
	760, cate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		-	23d. Date of de	
	Sox 6876 leath certificat e attending phy for use as the	sician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy		Month	Day Year
	Box 687 e death certifice the attending p ed for use as th	Physic	1 Yes 2 No 9 Unknown 9 Unknown				
	that the cred by the detached	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	rt I.	23e. Did toba		te to the cause of death? Probably 4 Unknown
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	cords, law requir has been s	Completed			autopsy perform	ed? dea	
	tal Recinant: The certificate		25. Was case referred to medical 26.Place of Death	Check only	1 Yes 2	No 1	Yes 2 No
	Vital ysician his cert directo	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4	Nursing Ho		esidence 6	Other:
	of ing Ph	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work		. Describe ho	w injury occurred	
	Sion Attend death. sctor:	catio	1 V Natural 5 Pending 1 Yes 2 Accident Investigation		Location (Str	oot and Number	or Rural Route Number, City
	Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined (Specify)	201	or Town, Sta		or real reals realist, only
	Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ice, and due	to the cause(s) and manner as	stated.
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occan and manner stated.	curred at the			
	19+1	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.			February 21,	(Month, Day, Year) 2008
3			30. Name and address of person who completed cause of death (Item 23a)				
•			Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Ba	ltimore, l	MD 21201		
		tate	31. Date filed Membra Day Year 2008 32 Registrar's Signature				
	Regis	uar	Lacialise de labora				

DHMH 17 Rev 1/2001

State

Registrar

0 2888

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Month Physician /Medical 4a. Facility Name (If not institution gife street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner timore Parkville Oakcrest Villag Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) December 13, 9. Birthplace (State or Foreign **Funeral** Days Hours Mary I and 1 □ M 2 € F 90 212-01-6653 1917 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Baltimore Baltimore 1 ☐ Yes 2 No "natural", or Items 23a or 28a-f shidical Examiner must be notifiled Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Boulevard Apt. 4318 21234 LISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Heath and Mental Hygiene. ant: if item 27 is marked other than "natural", or Iten Ly or other traumatic event, the Medical Examiner. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify White If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Hofferberth Catherine Storch ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce E. Amrein/Son 1213 Ambridge Road Bel Air Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Parkwood Cemetery 3/12/08 Baltimore Maryland 21. Signature of Funeral Service Licensee recharand Addriss & Facilia 5305 Harford Road Baltimore Maryland 21214 hustine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stage dementia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No eshve page 2 s autopsy nerform 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending 5 ☐ Pending investigation after death. 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated.

10

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Etosha

Dixon

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

Registrar's Signature

Walther Blud,

29c, License number

Parkville,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🗸 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ARCPAY 6, 2008 **Physician** 6:10A Anoff Bernard /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Towson Saint Joseph Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 76 Director MD March 24,1931 <u>213-28-8747</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2 No Directo MD Baltimore Freeland 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number a or d other than "natural", or items 23a event, the Medical Examiner must 21217 Ridge Road 21053 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 TYYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. **7 is marked other than** " Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Pharmaceutical 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ျှ Samuel Anoff Goldie Zimpt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn R. Anoff Wife 21217 Ridge Road, Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/12/08 Owings Mills, MD Garrison Forest Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASYSTOLE /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Veal 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown CARDIAC TRANSPLANT 1 Yes 2 No 3 Probably page 2 should Completed ngs available of cause of MYOCARDIAL I funeral director, 25. Was case referred to medical Certification:

ľ	NFARCTION		24a. Was an autopsy performe	24b. Were autopsy finding prior to completion death? ☑ No 1 ☐ Yes 2 ☑ No
	7	26. P	lace of Death (Check only one)	
	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4	Nursing Home 5 Residence	ce 6 ☐Other (Specify)
	28a. Date of Injury 28b. Tir		28d. Describe how	injury occurred

í	examiner?	i
	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation
5	3 ☐ Suicide	6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only
one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D46356

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYLAND 21204 TOWSON, OSLER DRIVE.

State Registrar

23a

within 72 hours after

death certificate be executed

Box 68760,

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Division or Vital Records,

certificate Physician:

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e Hospital or Attending P 24 hours after death. e Funeral Director: After t

within 24 hours at To the Funeral D

altimore, Maryland 21215-0036

hawn Junnie Bi	1	1- For State Certificate of Death	0755
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	ime of Death
ledical Exami		Shown Jumie Braxton Sr. March 5, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	10451115
		5000 East Monument Street Baltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthpla Country Months Days Hours Min.	
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5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	\
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5-0036 led within 72 hours after death with the Maryland Bygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Completed	12th Technician BTTS Corr	igated
5-00 iled wit Hygien d other	3	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	•
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	To Be	Calvin Junie Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zir.	Code)
MD d 2 shot Ith and n 27 is numatic	-[Demetria Branton 3104 E. Baltimore St. Baltimore, MD 212	34
S l an of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town Crematory or other place)	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: Greenmant Crematory 3/8/2008 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of aclity Vayon C. Oregne Funeral	MI)
Bal permi Depar Impo	1	21. Signature of Funeral Service Licensee 22. Name and Address of activity Vougan C. Oreene Funeral S 4905 York And Baltimore MI) 22 D	5Mice7
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Divisi pital or Att ours after de teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street 5000 East Monument Street , Baltimo	re , MD
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated. 20b. Signature and title of certifier. 29c. License number 29d. Date signed (Month	
	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month March 6, 2008	
		30. Name and address of person who completed cause of death (Item 23a)	
30		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
S Regis	tate	5.1 (\ 1.) 1) 71 (1.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2 (2.) 2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Brooks 5:01 AM March 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and r. Examiner Battimore sa Himore Hospital more If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, 1 ☐ M 2 😿 F 07.10.19 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at MD Baltimore 1 Nes 2 No **Funeral Director** items 23a or 28a-f 10g. Citizen of What Country? pe llaway death v Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 25No Baltimore, Maryland 21215-0036 Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired) College (1-4or 5+) Be ပ le, MD 21215 2 Cremation 3 ☐Removal from State 03.13.08 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice blut 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Spirato /Medical Examiner ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 1 🔲 Inpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide I 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a To the Funeral C Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier .0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave, Battimore MD Mason bnya MI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** William J. Blair 11:35 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pickers Gill Retirement Home Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1[XM 2□ F Yrs. 212-10-8790 95 February 7, 1913 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 LISA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distribution Manager permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other transment. Pittsburgh Paint Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augustus G. Blair Catherine M. Bucklev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Cedar Point Drive West Perryville, Maryland 21903 William J. Blair/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 3/10/08 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Leonard J. Ruck, INC 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Dementia months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease b. injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the ass IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March, 7,2008 & mo 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Jason Black, MD 6565 NOT The Charles ST Suite 209. Touson MD 21204 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

			For State Registrar	State of Ma	iryiana	-	rtment of F rtificate of I			Jiene leg. No. 🤈 🏻	108	07551
	Physicia	an	1. Decedent's Name (First, Middle, Las						2. Date of Dea	- 65	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	Ruth Bri	tton		4b City Town or	Location of Death	March 4	_	y of Death	12:50 A ^M
	Examin	er	Brighton Gardens	e street and number)			Pikesv				-	County
_25361	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last		If Under 1 Year Months Days		8. Date of Birtl (Month, Day	1		lace (State or Foreign
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	yland how at		10a. State 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
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	2 should be filed within 72 hours after death with the Maryland and Menth Hyglene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	Brighton Gardens	D 1			10f. Zip Code	21208		10g. Citizen of		utry? JSA
	death	nera	1840 Reisterstown 11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Ra	ce - Americ	
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TOL	00		XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		cem	etery, crer	matory or other placed	re) ¦				Maryland
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature i Funeral Service Licer		1	22 B1	Name and Addre	ss of Facility			•	-
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	Physician /Medical		disease or condition resulting in death)	a. Cere Due to (or as a			ombosi.	5				
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٥ ر	an and		that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):	· · · · ·					
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d								
Box 6	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. D	ate of delive	erv
<u> </u>	death le atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 No	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify) _	'			onth	Day Year
P.O.	ires that the de signed by the a I be detached f	Phy	9 ☐ Unknown * Part II. Other significant conditions of		ıt not resultir	on in the ur	nderlying cause giv	on in Part I	23e Did to	hacco use cor	tribute to th	ne cause of death?
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Division or	g Physer this eral di	n: To	1 ☐ Yes 2 X No 27. Manner of Death	28a, Date of Inju	y 28	Bb. Time of	I SOLDON	4 LI Nursing Ho	ome 5 Resid			V) Assisted Living
Sion	ending sath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident Investigation		rear)	Injury		Yes 2 □ No				
Š	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home :. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Furneral Director: After this certification properties of the funeral director, it completely filled in by the funeral director, it		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowle	dge, death	occurred at the tir	ne, date and place	, and due to the	cause(s) and n	nanner as s	tated.
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	10		Karen L. Babitt	, M.D. 700	0000	e con	rt Road,	suite 30	1, Balt	more	MD	21208
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 20	32 Registra	ar's Signatur	e	129 3 m					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#5perFH, G889, 3/26/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle_Last) Date of Death U 50 AM YOR R 2008 **Physician** BUDN ALE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner OSPITAL TRONE CT ERC If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year 7/12/54 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 217-56-**9763** Maryland 1**X**M 2□ F Months Director 53 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Invariant enter oceant with the Marylan Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 S. Charles Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: \$ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley John Budny Ann MArie Fittro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 Schoolhouse Lane Edgemere, Maryland 21219 Gary Budny / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 3/7/08 Baltimore, Maryland Loudon Park Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen 3620 Wilkens Ave. Baltimore, Md. 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter he disease, or con shock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsi **Physician** /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No ate has been signed by the a page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ WAE Na 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury М 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 3☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 05 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ()3 ()Aay 2008 1:00 PM Rita Theresa Coppolino /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2300 Dulaney Valley Road Apt. M306 Timonium Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🗶 F 0271371923 85 Maryland 216-12-6254 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 No Maryland Baltimore Funeral Director Timonium 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 21093 U.S.A. 2300 Dulaney Valley Road Apt. M306 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Clothing Retail 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salvator Coppolino Maria Lanza Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary lou Bayless- Niece 6012 Plumer Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 03/08/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. dised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part1. Enter the his ase, or complicat shock, or heart failure. List only one of Immediate Cause (Final onorector disease or conductors resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
i ysterializmen	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
pieted by Fi	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an abtopsy 24b. Were autopsy findings available prior to completion of cause of
5			performed? 1 Yes 2 No 1 Yes 2 No
וא	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)
2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)
ations.	27. Manner of Death Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurred
3	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29c. License number 036814

29d. Date staned (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard E. Huslig MD 7505 Osur DR. Suith 3º3

32 Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No., 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2038 M Clare Virginia Chapin 3 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Manyland Hidical Center 6. Sek If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, You April 2, Birthplace (State or Foreign Country) **Funeral** Year, 1 □ M 2 🖾 F Months Days 1923 Massachusetts Director 086-12-4049 84 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane RGT326 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret T. O'Brien John T. McCarty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health an Important; if item 27 is any injury or other trau-once. Clare M. Chapin Daughter 1630 Preston Road; Alexandria, Virginia 22302 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 3/14/2008 4 ☐ Donation 5 ☐ Other (Specify) |Springfield, Mass. 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses Kell Munas 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Large Right Frontal Parietal Lobe /Medical Due to or as a con a quence of): Examiner Hypertensian Securitally list condlines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last unknow Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed' 2 No To the Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ► Yo 1 Impatient 2 ER/Outpatient 3 DOA P this After the 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation within 24 hours are:
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

State Registrar Barret Land

Street

Baltmare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2008

S

32. Registrar's Signature

Greene

DUASSI

31. Date filed (Month, Day, Year)

March 5, 2003

			For	State of Maryland / Depart	artment of Health and	Mental Hygier	16) 0 0 0 7 5 5 9
			1 - State Registrar	Ce	rtificate of Death	Reg. I	No. 000 0 1330
#£	6 83		1. Decedent's Name (First, Middle, Last,	2		2. Date of Death	3. Time of Death
	Physic /Medi		FORREST R.	Crews , SR.		March !	Day Year 4 2108 11:15 PM
	Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dear		4c. County of Death
			Manor Care	TOUISON	TOWSON		Bo Himes
	Funeral		5. Social Security Number 6. Sec	1	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign
41.00	Director		231-16-7460	M 2□F 86 Yrs.	Mondia Days Hours Will	6-7-1	921 Country) /A
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 Oits Townson			
	anyla shov d at	7	TOD. COUNTY	10c. City, Town or Lo	ocation		10d. Inside City Limits
	he M 18a-f otifie	ectc	IND Dalti	nore Dun			1 ☐ Yes 2 ☐ No
	vith ti	Ö	10e. Street and Number	, , ,	10f. Zip Code	10g. (Citizen of What Country?
	death with the Maryland rms 23a or 28a-f show r must be notified at	Funeral Director	4504 Cleve		21222		U.S.A.
	er de item:	m		12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: // ℓ / ℓ / ℓ	1 ☐ Yes 2 ☐ No Specify:		Specify: Which
5-0036	72 hours after natural", or ite lical Examine	De la	15. Decedent's Edu	WW.II	dent's Usual Occupation	401	
15	n 72 n "na ledic	Completed	(Specify only highest grade	e completed) (Give	dent's Osual Occupation kind of work done during most of wo DO NOT use retired)	rking 160.	Kind of Business/Industry
2121	within ene. than "	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)	semples Tuen	1160 6	TENERAL Mators
	filed Hygi ther ent, t		17. Father's Name (First, Middle, Last)	7123	18. Mother's Na	me (First, Middle, Maid	10,00
an	d be ental ced c	To Be	John Edwar	ed Crews			on comand,
Maryland	should Mandal	F	19a. Informant's Name/Relationship (Ty)	-	ng Address (Street and Number or R	WOWN	v or Town State 7in Code)
Z	od 2 state and 2 s		Frank P Com	S.JRSON 650)4 N/da 1/ MD 21232
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Place of Dispo	a Cleveland of	Date 20c.	Location - City or Town, State
Baltimore,	ages ent of t: If it		1 Burial 2 Cremation 3 R		matory or other place)		
Ħ	iit. Partme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Dayvit	Name and Address of Equility To	1-08 1	Baltimore MD schon Funeral
Ba	permit. Departr Importa any Inj		A VIAI		L Name and Address of Facility	radley - H	SARING Rd 21222
-86;	1.4 18		23a Part1 Enter the disease or compli	cations that caused the death. Do not ent	one, PH, 2134	Willow	2p1/10/141:
			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	ier the mode of dying, such as caldia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Malnutrition			Weeks
	Examiner			Due to (or as a consequence of):			
		15	Sequentially list conditions,	. Due to (or as a consequence of):			
J	ted nsit	ij	If any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a consequence of).			
	xecu and	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
68760,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	E E		, ,			
587	ficate phys s the	edical	0				
×	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregnancy			004 D. 4 - 4 4 11
Вох	eath atter for u	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	the d y the ched	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	Jotner (appearly)		
σ,	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records,	uires ı sign id be	d by				1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	v req beer shou	ete					2
Re	: The law cate has I	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a	ilcian: Th certificate ector, pag		05.00			1 Yes 2 2 1	No 1 Yes 2 No
or Vital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?	ospital:	Other	ath (Check only one)	•
ō	Phys rthis raldii	٦.	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of	Nursing F	lome 5 Residence	
n o	ding Ph h. After th funeral	io	1 Natural 5 ☐ Pending	(Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	jury occurred
<u>S</u>	deatl ctor: / the	ical	3 Suicide 6 Could not be	28e. Place of injury - At home, farm, stre		Opt I posting (Otro-1	
Division	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	oot, ractory, office	City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death	a occurred at the time, date and place	and due to the course	(c) and manner on stated
	e Ho 24 h e Fur etely	Medical	(Check only 2 Medical Examir one)	er: On the basis of examination and/or invand manner stated.	vestigation, in my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)
	orithin or the original or the original	₩ We	29b. Signature and title of certifier		29c. License number	29d. D	Pate signed (Month, Day, Year)
	->-0		h R	1 / Mil	Doncling		
		-	30 Name and address of person who are	mpleted cause of death (Item 23a) (Type, F	D0061199	1,10	irch, 6, 2009
	H		Jason Black, MD	(156) And Ch	6: St C. I 209	To 5 4.	21204
- 4	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature	23 -1, 30112 201,	141)	21207
	Registr		MAR 1 0 2008	65-65 MOTH Charl 2. Registrar's Signature	EV.		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 55 **Physician** Isabelle Dorsey 0 -3 -06-08 /Medical 4a Facility Name (If not institution, swe street and number | ST. Elizabeth Records | St. Elizabeth Re beath inty of 4b. City, Town, or Location of Death Examiner Pitation MARS If Under 1 Year If Under 24 Hrs. 8. Date of Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye **Funeral** 1 M 2 F Days Min Months Hours 213 32.0209 YID Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show the Medical Examiner must be notified at MD. Baltimore 1 ☐ Yes 2 ☐No Director Bathmore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Choice have 303 21228 USA laiden 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☑ No Black Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm echnician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) t and 2 should be fit Health and Mental H tem 27 is marked off Partha Dorsey Kussell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Catonsulle, MD. 21228 Hve. Arunan 1200 Jelmaria (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 3-11-08 Woodlawn Itimore. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Valuation C. Breene Funeral Services
5151 Baltimore Nat'l Pike Balt 21. Signature of Funeral Service Licensee Balto. UD ZIZZ9 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Breast ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transit Due to (or as a consequence of): anding physician a use as the burial Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Dav ŏ Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 23 No 1 Yes 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only of e 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number Md D24766 March, 06/2008 Marden Chare hone Ballmore Md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAmien MI 32. Registrar's Sig 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

2008

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9, 2008 Andrew Bane Dillow 12:15P March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Director 88 VA Dec. 28,1919 228-14-2128 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₩ No Directo MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Chattolanee Hill Road 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\overline{X}\)Yes 2 \(\overline{\Overline{N}}\) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gardening Gardener 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Harvey G. Dillow Lillie Shewey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Virginia K. Dillow</u> Wife 409 Chattolanee Hill Road, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 YBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 3/12/08 Finksburg, MD <u>Evergreen Mem Gardens:</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ken Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cas resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (Stres a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) attending physician are for use as the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: nse 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has r this certificate has autopsy To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XIOther (Specify) # OSPICE 2 1 ☐ Yes 1 🔲 Inpatient 3 DOA 2 ER/Outpatient 27. Manner of Peath
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending within 24 hours are:

To the Funeral Director: Aft investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Towsartown Blud 2. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		,	Cei	rtificate of	Death		Reg. N	200	8 U/	299	
-4	Physicia		1. Decedent's Name (First, Middle, Las	st)					2. Date of D	eath	ay Yea	3. Time of	Death	
	/Medic		Winifred Elbourn					March March	6, 7	2008	2:00	\mathbf{P}^{M}		
	Examin	er	4a. Facility Name (If not institution, give			•	or Location of Death	1		c. County of De				
		- 100	3200 Everlasting 1 5. Social Security Number 6. S		(In yrs. las	t hirthday)	Middle If Under 1 Year	RIVer	8. Date of B		Baltimo	re irthplace (State o	r Foreign	
	Funeral Director	i.i.		ex 7. Age □ M 2 ⊠ X	79	Yrs.	Months Days	Hours Min.	09/11/	ay, Yea	r) (Country)	r Foreign	
	land ow at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside Ci	ty Limits	
	Mary -fsh fied	tor	Maryland Baltimon	re	Midd:	le Ri	ver					1 □Yes	2 /2/ No	
	th the	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What	Country?		
	23a cust b	ral	3200 Everlasting 1	Lane			212	220		Ţ	J.S.A.			
	tems	Funeral	11. Marital Status	Was Decedent E Armed Forces?		13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	lo-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.		
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2, □ ★ If Yes, Give Year or Dates:	0		1□Yes XX No	Specify:			Specify:	White		
<u>7</u>	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	dent's Usual Occup kind of work done	oation during most of wor d)	king	16b.	Kind of Busines	ss/Industry		
7	withir ene. than the Me	dmc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		etary	u)		Gei	neral O	ffice		
D	e filed val Hygie other i		17. Father's Name (First, Middle, Last)			DCCI	cur,	18. Mother's Nan	ne (First, Middl					
land	should be and Mental s marked o umatic eve	To Be	Leroy Merriken					Helena K	ief					
ar	2 should be and Mental is marked raumatic ev	_	19a. Informant's Name/Relationship (7				-	and Number or Ru						
, Ma	1 and 2 Health a tem 27 is		Robert Hartnett (Son)				ern Avenu		· ·				
MOFE Pages 1 and of He	Pages 1 nent of H int: if iter		20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		1		sition (Name of matory or other place Of Faith		Date 0/2008		Location - City :	or Town, State Marylan	đ	
Baltimor	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Funeral Service Licen	see		1	Name and Addre	ess of Facility ruzdzinsk Eastern A	i Funer	al I	Home, P	.A.		
		7	23a. Part1. Ent whe diem se, or companies shock, leart failure. List only	plications that caused	the death.				-		*	Approximate Interval Bets		
	Physician		Immediate (ause (Final disease or c	Vm	- Hoo	[] L		monom				Onset and I	Death	
	/Medical		resulting in death)	Due to (or as a				10770	. •			7		
	Examiner		Sequentially list conditions,	b		V		_ !						
h.	sit sit	ine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as s	t consoquer	nee of).								
Ĭ	and and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	nce of):								
08/00	certificate be executed adding physician and use as the burial-transit			,		,								
200	ificate g phys	Medical		d										
O. BOX	death ce e attend d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome particle birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal d	eath 3]Ectopic pregnanc]Other (specify) _	у			23d. Date of o	,	Year	
ds, r	requires that the sen signed by the	þ									23e. Did tobacco use contribute to the cause			
cords,	v requ	Completed							24a. Wa			autonou findingo	available	
ğ L	he law e has b ge 2 st	ш							aut	opsy formed?	prior t death	autopsy findings : o completion of ca ?	ause of	
VII	ifficate or, pa		25. Was case referred to medical			·		26. Place of Dea	1 Yes		1 🗆 Y	es 2 No		
>	ysicia s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2□EF	R/Outpatien	t 3 DOA Oth	or.	6		6 ☐Other (S	necify)		
5	ig Phr ter thi		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 2	8b. Time of			28d. Describe					
VISION	endir ath. or: Af he fui	atio	2 ☐ Accident investigation					Yes 2 □ No						
Ĕ	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At hom . <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or To	(Street a	and Number or ate)	Rural Route Num	iber,	
_	pltal ours at eral C		200 Cartifier 17 Cartifuing Ph	veielen. To the heat o	f my lenguel	odao dooti	a conversed at the sti	imo doto ond sleer	L and due to the		(a) and manner	no stated		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		ysiclan: To the best on niner: On the basis of and manner sta	examinatio								5)	
	ro the vithin ro the	Me	29b. Signature and title of cedifier				29c. Licens	se number		29d. E	ate signed (Mo	nth, Day, Year)		
ì	->-0		& Solvet 1	/		-	1000	156910	(0	03/07	108		
	18		30. Name and address of person who	completed cause of de	ath (Item 2	За) (Туре,	Print)	se number 5691 ° 'S ST, S				1		
	Sta	te.	DR. ROBERT DO 31. Date filed (Month, Day, Year) 20	Registra	569 r's Signaty	N.	CHARLE	5 51, 5	TE 205	>,	10W30	V,MD 2	12-64	
	Registr		MAR 1 0 20	UB CAR	0									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** Fave Louise Evans 5. 7:11 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Belair Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 3, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 86 234-36-8833 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Be Completed by Funeral Director Maryland Harford Abingdon 1 ☐ Yes 2 ☑ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ltem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 303-303 Tiree Court 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 is marked o George Clemson Margaret V. Blair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye E. Milio/Daughter 100 W. Ring Factory Road Belair Maryland 21014 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springfield Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/08 Sykesville Maryland Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Christina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE METABOLIC ACIDOSIS **Physician** horace /Medical Due to (or as a consequence of): Examiner MULTISYSTEM ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner SEVE RE SEPSIS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsv performe Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) necea greek my 30. Name and address of person who completed Galise of death (Item 23a) (Type, Print) 500 NATRICIA GURN, MD UPPER CITES A PEAKE MEDICAL CENTER BEL ATR, MARY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2008 Henry G. Fischbach 4:05 PM March 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□F 215-07-8705 98 1909 Maryland Director 14, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Towson 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 21204 615 Chestnut Avenue, Apt. 1422 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 XYes 2 No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Underwriter Insurance should be filed wanted Mental Hygiel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry G. Fischbach Addy C. Bohne and 2 should the sealth and Meni m 27 is marked ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 615 Chestnut Avenue, Apt. 1422; Towson, Maryland 21204 Mary B. Fischbach Health a permit. Pages 1 a. Department of Heal Important: If item 2, any Injury or any Injury o other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/11/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1401490 1630 Edmondson Avenue; Catonsville, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic MONTHS **Physician** 13 ANa /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death led by the a detached f 9 Unknown 9 Unknown signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Tyes been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 No 1 [] Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera After t 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

death certificate be executed Box 68760, P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral L 204

Hospital 24 hours a

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

Se Butter

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(1565N. Charles ST. Suite 209 Baltimore udzizoy ~ MD 65 (Dobernar DaNIElle 31. Date filed (Month

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:10 A Goddard March 3, 2008 Anne Marquerite /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Laurel Laurel Regional Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X□ F 217-28-8232 Sept. 4, Maryland 90 1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a, State 10b. County 1 ☐ Yes 2 No Prince Georges Laurel Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 USA 16117 Malcolm Drive items 23a Pages 1 and 2 should be filed within 72 hours after death w nent of Health and Mental Hygiene.

ant: If fear 27 is marked other than "natural", or items 23a mir; If item to 27 is marked other than "natural", or items 21s ury or other traumatic event, the Medical Examiner must. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√0 No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Bond Henry Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16117 Malcolm Drive, Laurel, MD 20707 Virginia Plisko- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1) Burial 2 ☐ Cremation 3 ☐ Removal from State St. Georges Cath. Church Cem. 3/7/2008 Walley Lee, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral rvice Licensee Fieck Funeral Home, INC. 6 MO/134 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of):
Chronic Obstructive Pulmonary Disease Examiner Sequentially list conditions, it any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Valvular Heart Disease law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 4 Pregnant at time of death signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1∐ Yes 2 I or Attending Physician: after death. funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Iniury To the Hospina. within 24 hours after death.

To the Funeral Director: Aft

To the Funeral Director: Aft 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D0064760

March 3, 2008

08-01815	
Maurice R.	Glover

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Mec		nysici Exami	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Da	y Year	3. Time of Death 0425 hrs					
اتان المان	ilcai i	LAGIIII		MAURICE R. GLOVER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	March 4, 200	4c. County of Death						
				Bon Secours Baltimore		N/A						
		neral ector		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 213 62 3794 1. M 2 F 55 Yrs.	_ `	M/DD/YYYY) 9. Bir Foreig 1952 ^{Co}						
		any	ŀ	Usual Residence of Decedent 10a. State			10d. Inside City Limits					
	pue	≥	ě	MD N/A BALTIMORE			1 X Yes 2 No					
1	more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland	lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at once.</u>	Director	10e. Street and Number 2304 WINCHESTER ST. APT.I 10f. Zip Code 21216	10g. (Citizen of What Cou	ntry?					
1	r death wit	or items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St. 14 Never Married 2 Married 12 Never Married 2 No. 14 Never Married 15 No. 15 No. 16		White, etc.	ican Indian, Black,					
	urs afte	tural";	ক্র	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of various)		Specify: BLA b. Kind of Business/						
	036 thin 72 ho	ne. r than "na ledical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12TH SECURITY GUARD	J	OHNS HOI OSPITAL	PKINS					
	21215-0036 ould be filed within 7	Hygie d other			(First, Middle, Maid							
	212'	Mental I marked c event,	To Be	JAMES GLOVER MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Z JENNIN Rural Route Number		e, Zip Code)					
	MD id 2 sho	th and 1 27 is umati		KATRINA GLOVER (sister) 2304 WINCHESTER S								
	Baltimore, MD 21215-00; permit. Pages 1 and 2 should be filed with	Department of Health as Important: If item 27 injury or other traums		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) MAR GREEN MOUNT CREMATORY	.10.2008	Oc. Location - City of	Town, State					
	Balti permit.	Departm Imports injury o		21. Scinature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUCT 1412 F. PRESTON 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of the complex of the control								
		sician edical		failure. List only one cause on each line.		shock, of heart	Detween Onset and					
Kr.		miner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovasculer Di Due to (or as a consequence of):	sease		Death					
			Jer	Sequentially list conditions, if any leading to inmediate b. Justo (or as a consequence of):								
	pa:	ed isit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
	e execu	ician and irial - tra	Medical	X UNPENDED AMENDED AMENDED 120 fives outcome of prepagative.	7 3/13/08	reb						
	68760, ertificate be	ding physi e as the bu	an/Me	23b. Was decedent pregnant in the past 12 months? 25b. Was decedent pregnant in the past 12 months? Fetal death 3 Ectopic pregnant in the past 12 months?		Lou. Bute of donie	ry Day Year					
	Box 687 e death certific	the attened for us	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)								
	P.O.	signed by be detach	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease			o the cause of death?					
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed	his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit	Completed		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of					
	al R	ertifica ctor, pa	Be C	25. Was case referred to medical 26.Place of Death (Check								
	F Vit	r this cral dire	입	Yes 2 No	ng Home 5 Re	sidence 6 Othe	er:					
	n o	th. r: After e funeral	ion:	27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	280. Describe now	rinjury occurred						
	Division Atte	rs after death al Director: led in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) (Spec								
87	the Hospit	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s at the time, date and) and manner as sta d place, and due to t	ated. the cause(s)					
U	To	To Con	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number	2	9d. Date signed (M	onth, Day, Year)					
				Down mudinal M.D. O.C.M.E.	N	March 4, 2008						
				Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, Marchael Company (Item 23a)	MD 21201							
			tate	31. Date filed (Month, Day, Year) 0 32. Registrar's Signature								
		Regis	trar	MAR 1 0 auto								

State Registrar

Rose

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 K Months Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 No Director Timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Be Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ac Widowed 4 ☐ Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Sister eigh, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee l 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTYNCTIVE PULMONAN ISEASC CHRONIC Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last enolitions tell vilethouse Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CArcinoma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Anemia 24a. Was an certificate has page 2 autopsy performed 1 Yes 8 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler

Division or Vital Records, P.O. Box 68760,

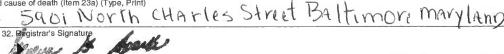
State Registrar

31. Date filed (Month, Day, Year)

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Um mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

35102

Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 9, 2008 ELWOOD CAREY HEWITT 6:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F 93 Director Feb 26. 1915 North Carolina 180-12-3288 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore County Director Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Belmont Forest Court, #207 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21又No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alethea T. Chappell Robert A. Hewitt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy R.. Hewitt (Wife) 205 Belmont Forest Court, #207, Timonium, MD 21093
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Grdns 3/13/08 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 21. Signatur of Funeral Service General Service General Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a year of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the be detached 9∏Unknown 9 ☐ Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No RECURRENT PLEURAL EFFUSION 24a. Was an page 2 s has autopsy performed certificate 2 No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**5** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 88 D37254 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON. MARYLAND 21204 BOOM POH LIM. M. D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 MAR 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy Jamison Harbin 2008 8:30 A^M March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care - Dulanev Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 XF 80 26, Director 212-22-3846 April 1927 Maryland Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2 X No **Funeral Directo** Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 9508 Buckhorn Rd. 21234 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. þ Specify: white 3X Widowed 4 □ Divorced "natural" d Mental Hygiene.
marked other than "natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) interior designer home design 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel W. Jamison Caroline Shipley ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i Lisa B. Van Bavel/daughter 9508 Buckhorn Rd. Baltimore, MD Important; If item any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's-Govans Cem. Mar. 10,2008 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Iminediate Cause (Final **Physician** s a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause E to U John Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ဥ 1 ☐ Yes No. 2 ER/Outpatient 3 DOA 4⊠Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: A in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral DI completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month. Dav. Year) 1600

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

MAR 10

32. Registrar's Signature

		For		State	of Ma	aryland					nd M	ental Hy	giene	2008	}	7571
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	Rican, etc.)	Black, Whi	te, etc.		
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Maryland	id 2 st ith and 27 Is n traun		19a. Informant's Name/Relationship (Tammy L. Appold (**			and Number or Rural treet, Bal					
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Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm, st <i>ecify)</i>	reet, factory, office	28	8f. Location (Stree City or Town, S	et and Number or Fi State)	ural Route Number,		
Ц	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in I		29a. Certifying Pl	nysician: To the best of my	knowledge, dea	th occurred at the tir	me, date and place, a	nd due to the caus	se(s) and manner a	s stated		
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	10		30. Name and address of person who Bay nadell C_S	aton up 12	Courth	Print)	st Balt	moo, Y	WD 7/12	101		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year **Physician** Month 5, Edna P. Hammond March 11:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Summitt Park Nursing Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/16/1916 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1□M 2**X**F Director 215-03-5659 91 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatte event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 X No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 Ridge Drive 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be James Wilson Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. Laurie A. Berryman / Grandaught 2402 Old Frederick Rd., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Bayview Crematory 3/6/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 dos /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes Ø No Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🕭 ☑ Únknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ♠ No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 144 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a To the Funeral I

State

29b. Signature and title of certifie

31. Date filed (Month, Day,

man

MAR 1 0 2008

Year)

Registrar

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

08-01426 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sharnette Wendi Hayward Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 18, 2008 2038 hrs **Medical Examiner** Sharnett Hayward 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Riverdale 6831-C Riverdale Road #202 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If I Inder 1 Year If Under 24Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Міл Director 11-30-1960 Country) N. J. M 2 X F 47 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 Yes 2 X No Prince Georges Riverdale Pages I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20737 6831 C Riverdale Road #202 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Black If Yes, Give Year Yes 2 X No specify: Specify: Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed N/A during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' Executive Asst 12th grade Department of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sandra Richard Hayward Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic MD Hanover, MD 21076 Hassan Muhammad-Brother Craghill Court 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify Rosehill Cemetery 2-29-2008 Linden 22. Name and Address of Facility March F/H East nature of F rai Service Licensee 21202 Mulle 1101 E North Avenue MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Contact gunshot wound of head Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit law requires that the death certificate be executed Physician/Medical X AMENDED23a, 27, 28a-f per ME g877 3/14/08 amh UNPENDED the attending physician ed for use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 No 3 Probably 4 Unknown ۵. Completed Records, ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? The ✓ Yes 2 No 1 🗸 Yes 2 No certificate the Hospital or Attending Physician: thin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital 8 examiner? Hospital: Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 ✓ Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 2/18/08 ay subject shot self Natural 8:25 pm found 1 Yes 2 X No Director: Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be or Town, State 6831-C Riverdale Rd, #202 (Specify) found at home determined To the Funeral Riverdale. MD Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 19, 2008 30/ 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

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Registrar

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Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. To the Hospital o within 24 hours aft To the Funeral DI completely filled in

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

attending physician and

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after death i Director: d in by the f

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Registrar

Medical

31. Date filed (Month Day, Year) 0

29b. Signature and title of certifier

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29a. Certifier

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

REGOOD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Montharchy 6, 2008 8:16A KATHERINE H. HALLER 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 X 1 F 215-09-8235 92 /12/1915 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE TOWSON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 615 CHESTNUT AVENUE 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERNARD OTTEN HELEN TUGWELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICHOLAS HALLER/SON 1719 ALICEANNA STREET BALTIMORE, MD 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 3/8/2008 | CATONSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lic THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the cause of th Due to (or as a consequence of): CANCER OF LUNG resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Physician /Medical Examiner

death certificate be executed

P.O. Box 68760.

Division or Vital Records.

Physician:

Attending

Physician

/Medical

Examiner

Funeral

Director

28a-f show Ħ a or 28a-f she be notifled a

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permit. Pages 1 Department of H Important: If Ite any Injury or ot

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within 72 hours after

Baltimore, Maryland 21215-0036

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and A the burialattending physician Physician/Medical as use Por ð Completed been has certificate ector, Be P this After Certification: To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A death. in by the

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Registrar

1□ Yes 2, No 26 Place of Death (Check only one)

1 🗌 Yes

ER/Outpatient	3 🗆 🛭	Other:	4 ☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)							
28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how inju							
ome, farm, stree	t, facto	ory, office		28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)						

2	Certifying Physl	clan: To the best of my k	nowledge, death occurred at the	time, date and place,	and due to the o	ause(s) and mar	nner as stated.
2	Medical Examine	er: On the basis of exami	nation and/or investigation, in my	y opinion, death occur	rred at the time, o	date and place, a	and due to the car
	\neg	and manner stated.					

29b. Signature and title of certifier

1 / Inpatient

28e. Place of injury - At he building, etc. (Specif

(Month, Day Year)

28a. Date of Injury

29c. License number D52749

29d. Date signed (Month, Day, Year) 03-06-08

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE, TOWSON, MARYLAND 21204 M.D. 769 32. Registrar's Signature 7601 P HIRPARA TAYANT 31. Date filed (Month. Day, Year)

5 ☐ Pending investigation

6 Could not be determined

25. Was case referred to medical

2 No

1 ☐ Yes

27. Manner of Death

1/ Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28a per dr., g877, 03/10/08/16/19 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month EB Year Physician 14:10PM Malisie Irene Hoffman 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Agnes timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🗑 F 212-36-3565 Yrs. VA 30 Director 1935 Apr Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21229 4313 Wilkens Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify ò Specify: white 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) health care nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Lee Worley Nathaniel T. Mingee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4316 Harney Rd., Taneytown, MD 21787 Emory T. Mingee (brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-20-08 Sykesville, MD Lake View Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHaight Funeral Home & Chapel Parge Harger Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division or Vital Recórds, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ti 2

State Registrar

31. Date filed (M

DHMH 17 Rev 1/2001

MACISI

30. a add ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** 11:15 AM HARIES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keswick Home Baltimore N/A if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan.14,1930 9. Birthplace (State or Foreign Country)
Pennsylvania Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 X M 2 □ F 78 Director 165-24-2330 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Timonium 10e, Street and Number 10g. Citizen of What Country? 10f Zin Code or Items 23a or Medical Examiner must be 21093 210 Belmont Forest Court, Unit 408 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1**X**1Yes 2□No If Yes, Give 1952-1954 Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: þ 3 Widowed 4 Divorced 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Insurance Company Manager permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If Item 27 Is marked other 1 any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles В. Hammer Esther Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 210 Belmont Forest Court, Unit 408 Timonium, Maryland Doris J. Hammer Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-10-2008 Hilltop Service Corp. Towson 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature & Fundral Cervice Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Towson, Maryland 21204 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): arternacloratic heart disease Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ embelic skirkes 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Sibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has Parkinson's advanced 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 No 2 this 27. Mann o Death funeral 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Whatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 013657

1071

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Sig

TRABELLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



100 W. 4 Oth Street, Backwar, Ma 21211

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 2008 7:50 A M Virginia Antoinette Hartner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Brighton Gardens Towson Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 0770371915 Months 212-18-2693 92 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐Yes 2 No Director MD Baltimore Towson 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 12 should be filed within 72 hours after death with I hand Mental Hygiene.
7 Is marked other than "natural", or Items 23a or : traumatic event, the Medical Examiner must be n 6451 N Charles Street, Room 235 21212 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Truman C. Grove Anna Margaret Nagengast 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Gary Hartner/Son 602 College Ave., Lutherville, MD 21093 of Health 8 Department of Heali Important: If item 2 any injury or other once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Hilltop Service Corporation 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 03/14/08 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner UEARS CORONARY ALTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq nce of) Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical certificate the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. à 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED LIVING 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. uneral Director; A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64395 MARCH 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUL DOBERMAN, MO 6565 NOHARLES ST. SUITE 209 BALTIMORE, MB 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Septem 1 10 Registrar

Usual Residence of Decedent 10a. State 10b. County MD Montgome 10e. Street and Number 901 Arcolla Avenue 11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educy (Specify only highest grade Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Ty, Clinton Nursing & 20a. Method of Disposition 1 Burial 2 Cremation 3 B 4 Donation 5 Other (Specify) 21. Signature of Eneral Service Licens Ronald 22a. Partl Enter the diseas, or comp shock or heart failure. List only or Immediate Chee (Final disease or condition resulting in death)	**Rehab **A	yrs. 13. Walling 15. 16a. Decede (Give king) yrs. yrs. 19b. Mailing 9211 yrs.	Spring 10f. Zip Code as Decedent of H fes, specify Cuba Yes 2 No It's Usual Occup Ind of work done O NOT use retired unk Address (Street Stuart I tion (Name of altory or other place Name and Addre That Ltimore,	20902 Hours Mi 20902 Hispanic Origin? an, Mexican, Puscient, Puscient, Puscient, Puscient, Puscient, Puscient, Puscient, Puscient, Manager, Manager, Puscient, Pus	(Specify Yes or Note of Rican, etc.) Way 6, (Specify Yes or Note of Rican, etc.) unless of the control of th	1950 10g. Citizen of What USA 14. Race - Ar Black, W Specify: W 16b. Kind of Busines 20735 20c. Location - City Baltimore	George's Brithplace (State or Fore Country) 10d. Inside City Lim 1						
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shock or heart failure. List only or Immediate C h. e (Final disease or condition resulting in death)	ne cause on each line. Responsible	FAIlm				arrest.	Approximate Interval Between						
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Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		101				1						
Cause (Disease or injury that initiated events resulting in death) Last	C		of B for	· Y '									
if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Sept 1' Cerris													
	d	-cours											
!F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna					23d. Date of	delivery						
in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d			:y 		Month	Day Year						
9 🗆 Unknown													
	· .	_	lerlying cause giv	ven in Part I.									
	Hereste C												
	Hypo Mynid	*			— auto	opsy prior	e autopsy findings avail to completion of cause						
	Mubit ds.	esty			1□ Yes	2 ☑ No 1 LIY	res 2□ No						
examiner?	Hospital:	FD/Outrationt	all pos Oth				2						
27. Manner of Death	28a. Date of Injury	28b. Time of					specify)						
1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury											
3 Suicide 6 Could not be	Zoe. Flace of injury - At he	ome, farm, stree fv)	et, factory, office		28f. Location	(Street and Number or	r Rural Route Number,						
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(Check only 2 Medical Exami	iner: On the basis of examina												
	and manner stated.		29c Licens	se numher		29d Date signed (M	looth Day Year)						
/	a K	MA											
	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions condit	25. Was case referred to medical examiner? 1 Natural 2 No Homicide 28a. Date of Injury (Month, Day Year) 29a. Certifier (Check only one) 29b. Signature and title of certifier 1 Ness 12 No Service of the pregnant at time of december 1 ness 12 ness 12 ness 13	25. Was case referred to medical examiner? 1 Yes 2 No No No No 25. Was case referred to medical examiner? 1 Yes 2 No No No 25. Was case referred to medical examiner? 26. Was case referred to medical examiner? 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 20 Accident 29b. Signature and title of certifier	25. Was case referred to medical examiner? 1 Yes 2 No No No No 25. Was case referred to medical examiner? 1 Yes 2 No No No 25. Was case referred to medical examiner? 1 Yes 2 No No 26. Was case referred to medical examiner? 27. Manner of Death No No No 28a. Date of Injury No No 29a. Certifier (Check only one) No No 29a. Certifier (Check only one) No 29b. Signature and title of certifier 29c. Licen 2	25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Inpatient 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 Yes 2 No 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 1 Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. Place of Injury 26. Place of Injury 27. Manner of Death 1 Nother 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of injury At home, farm, street, factory, office 28c. Place of injury 28c. Place of in	Check only one Chec	236. Was case referred to medical examiner? Check only one City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29d. Date signed (Mathod of the cause (s) and manner stated. 1						

DHMH 17 Rev 1/2001

08-01833

Villiam Hyman		State of Maryland / Departme For State Certifica	ent of Health and Menta ate of Death	al Hygiene Reg.	200	8 0758
Physicia	1	egistrar I. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death 1824 hrs
Medical Examin		William Andrew Hyman Ha. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	Month D March 4, 20	08 4c. County of Death	10241115
A		933 Lemmon Street	Baltimore			
Funeral Director		5. Social Security Number 212–46–3056 6. Sex 1 M 2 F 7. Age (In yrs. last birth	day) If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth (Min. July 31,	Cou	hplace (State or Foreign untry) MD
w any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of MD	or Location Baltimore			10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once	힑	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	
with the Mar ns 23a or 28 be notified a	Dire	933 Lemon Street	21230		USA	can Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	元 I	11. Marital Status 1 ☑Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒️ No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I		White, etc.	Black
ural",	출 -		1 Yes 2 XX No specify: Decedent's Usual Occupation (Give ki		Specify: 6b. Kind of Business/	
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours a nt of Health and Mental Hygiene. It: If item 27 is marked other than "natura other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Juring most of working life. DO NOT u	se retired)		unk
5-0036 led within 7 Hygiene. lother than	Ĕ -	17. Father's Name (First, Middle, Last)	laborer 18.Mother's	Name (First, Middle, Ma	niden Surname)	
215 be filed ntal Hy rked of	8	Frank James Hyman		Irene V. M	forgan_	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	₽[19a. Informant's Name/Relationship (Type, Print) Edward Hyman / Brother	. Mailing Address (Street and Numb 4404 Fiddlers Road;			e, Zip Code)
e, M 1 and 2 Health Health item 2	1		f Disposition (Name of cemetery, ory or other place)		20c. Location - City or	Town, State
MOF Pages nent of ant: If		4 Donation 5 Other Specify:	Crematory		Catonsville,	
Balti Sermit. Separtn mport	-	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 638 N. Gilmor Str		1 Home, P.A.	
Physician	-	23a. Part I. Enter the disease, or complinations that caused the death. Do no				Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic intoxic		Death		
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
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Box 6876 re death certificate the attending phy hot for use as the	Physician/N	past 12 months? 4 Pregnant at time of death	Other (Specify)			,
. Bo the deat y the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Pa	rt I. 23e. Did tot	pacco use contribute to	the cause of death?
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ital ician:	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/O	26.Place of Death outpatient 3 DOA Other		Residence 6 V Oth	er: Scene
of V ig Phys fter thi neral di	<u>ا</u>	1 V Yes 2 No	Time of Injury 28c. Injury at Work		ow injury occurred	
ion ttendin leath. for: A	atior	Natural 5 Pending Fnd 3/4/2008 un				D the state of
Division of Vital Records, P.O. Box 68760, ria for Attending Physician: The law requires that the death certificate be as a fler death. **Al Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burner.	Certification:	3 Suicide 6 Could not be determined (Specify) home	arm, street, factory, office building, et	or Town, St		Rural Route Number, City ore MD
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and pla investigation, in my opinion, death oc	ace, and due to the cause curred at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)
To To Con	Med	29b. Signature and title of dertifier	29c. License number		29d. Date signed (M	lonth, Day, Year)
		(Cantoled)	O.C.M.E.		March 5, 2008	
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, M	D 21201		<u> </u>
St Regist	ate	31. Date filed (Month, Day, Year) MAR 0 7 2038	4.2			
DHMH 17 Rev 1/2		INFALL STATE OF THE STATE OF TH	RIGINAL			

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UNK UNK		State Maryland / Department of Health and Meinal Hyg Certificate of Death		200	8 0758
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Medical Examin			March 3, 20	008	2254 hrs
Character of the Control of the Cont		4a. Facility Namé (if not institution, give street and odmber) 4b. City, Town, or Location of Death University Hospital Baltimore		4c. County of Death	
Funeral		- Interest y 7.55p.t.s.	8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or Foreign
Director		218-78-2628 1 F 35 Yrs. Months Days Hours Min. Usual Residence of Decedent	08-0	1.1972 00	untry) M.b.
d how any	_	10a. State 10b. County 10c. City, Town or Location Rathmore			10d. Inside City Limits 1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatte event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 847 Brinkwood Road 21229	100	g. Citizen of What Cour	ntry?
n with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Values Novince) 14. Marital Status 15. Was Decedent of Hispanic Origin? (Specific Values Novince) 16. Yes, specify Cuban, Mexican, Puerto R		14. Race - Ameri White, etc.	can Indian, Black,
after death al", or iter	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: BI	ack
hours natur Exami	ed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retired	rk done d)	16b. Kind of Business/	Industry
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Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Nental Hygene. Important: If item 27 is marked other than nijury or other traumatite event, the Medica.	۴	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru Mary Tackson (Mother) 847 Brinkwood	Rd K	Ser, City or Town, State	. 21229
S, M and 2 leafth item 2 traun		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
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altir mit. P partme porta	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ree		10ml Sema	29.
		Vallagent & prelie 515 Battinore	Nat'l P	ike Balt	0 MD 21229
Physician /Medical		23a. Part I. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arre	st, shock, or neart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Dealit
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876 tificate	Ž/L	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan	псу		y Day Year
Box 68760, e death certificate by the attending physic ed for use as the but	sicia	4 Pregnant at time of death 5 Other (Specify)		1	10
by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.O. es that the igned by be detact	d by		1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
rds, requir	letec		24a. Was a		utopsy findings available completion of cause of
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a second the control of the funeral director.	Be C	25. Was case referred to medical 26.Place of Death (Check o	nly one)		
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n of ding I . After	e ::		280. Describe in Subject shot	low injury occurred	
Sio Atten r deatl ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or R	ural Route Number, City
Div ital or rra Bir ifed in	Certification:	Suicide 6 Could not be	or Town, St 2800 Block of	tate) West Lafayette Stre	et, Baltimore , MD
Division of Vital Records, P.O. Box 68760, To the Hospital or etificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To vit	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
A \ \ \		Theodox M. Vin Try, man O.C.M.E. OC	ME	March 4, 2008	
- iy		50. Name and address of person who completed cause of death (Item 23a)	MD 04004		
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore 31. Date filed (Month, Day, Year)	, IVID 2 1201		
St Regist	ate trar	1 A 70118 618-9-2-2 A			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03/05/2008 Barbara L. Jones-Reitzloff 4:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Nursing Home Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Dav. Year) Months Days 1 □ M 2K□ F 226-96-3502 50 Director 08/30/1957 Kansas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at MD 1 ☐ Yes 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 1396 Buckhorn Rd. 21784 USA Funeral "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Year or Dates: other traumatic event, the M. dical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than College (1-4or 5+) Elementary/Secondary (0-12) D.V.M. Carroll Co. Vet. Clinic t 2 should be filed w
 h and Mental Hygie
 7 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David L. Jones Barbara Hafford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 ls Daniel A. Reitzloff/husband 1396 Buckhorn Rd., Sykesville, MD 21784 Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If in any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State South Carroll Crematory 3/6/08 Winfield, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 2Burrier Cuceri Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease r condition **Physician** he esulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. attending physiciar Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 mon Month Year Day 5 Other (specify) signed by the a 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has perform certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No the 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death To the Funeral Director: To the Hospital within 24

10

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Manchester MD 21102

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 3, 2008 4:30 PM Verena Mae Jennings 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore City 2809 Ailsa Ave. n/a If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, May 28, Hours 1 M 2 F Months Days Oklahoma 443-40-0228 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2/YNo Yakima Yakima 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 98908 USA 528 Hennessy Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married white 1 ☐ Yes 2 🗷 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Florence Taylor Virgil Hanks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18813 Vista Road, Columbia, MD George Jennings (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/14/08 Hickory Cemetery Hickory, OK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Metastatic Colon Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notified at

"natural", or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If flem 27 Is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Evanture.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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attending physician and ģ this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be execute.

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be မ Certification:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter or denting Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Daughter's Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MYSICIAN

29b. Signature and little of certifier

Do066 507

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person o completed cause of death (Item 23a) (Type, Print)

University of Maryland 22 S. Greene St. Baltimore, MD 21201 Naimish Pandya, MD 32 Registrar's Signature

State Registrar

Medical (

				For State Registrar		State of	of Maryla	nd / D	epartme Certifica	ent of H	lealth an Death	d Ment		lives for the	8	075	86
				Decedent's Name (First, Middle, La	st)						2. Da	ate of Death	J. No.		3. Time of E	Death
		Physic /Medi		Harold	LeR	.oy	Krebs					J-M	brvar		Year 2008	8:45	2 Р. М
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			The state of the s	St. Agn		spital				Balt	imore	_]	N/A		
		Funeral		5. Social Security Num		Sex / MADM 2□F	7. Age (In yrs		Mont	der 1 Year hs Days	If Under 24 I Hours N	Hrs. 8. Da	ate of Birth fonth, Day, Y	(ear)	9. Birthpi Coun	ace (State or	Foreign
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		or 28g	Director	10e. Street and Number	ər				10f.	Zip Code			100	. Citizen of W	hat Coun	try?	
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		tema tema	Funeral	11. Marital Status		12. Was Dec Armed Fo			13. Was De	cedent of Hi	ispanic Origin In, Mexican, Pi	? (Specify Y	es or No-	14. Race Black	- America		
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7-	Ş	tural tural	ed t		5. Decedent's E	Year or E	Dates: 1	947	Decedent's U	Isual Occup	ation		10	ib. Kind of Bus	Wh:		
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67	212	filed within 72 hours after Hygiene. ther than "natural", or Ite int, Ite Medical Exemine	Completed	Elementary/Second	ary (U-12)	College (1-401 5+)	B1	ue Pr	int Er	ngineer			Manfa	ctur	ing	
4	p	al Hy d other	Be	17. Father's Name (Fin	st, Middle, Last,)								iden Sumame)		
#	<u>yla</u>	should be nd Mental r marked o	2	Clayton	Krebs						Fu	rn Mi	ller				
	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow apprintury or other traumatic event, the Madical Examiner must be notified at ance.		19a. Informant's Name										City or Town, S			
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		and and I-tran	хаш	Cause (Disease or influ that initiated events resulting in death) Las		c. Due to	(or as a conse	nuence of	١٠		Do	× 13°	OVED		_		_
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	687	lticate g phys	edical		_	d					Ç.						
	Вох	death certition attending plater use as	Physician/M	fF FEMALE: 23b. Was decedent pr	egnant	23c. If yes, out								23d. Date	of delive	v	
	œ.	death	icla	in the past 12 mo	nths?	4☐Pregr	oirth 2 ☐ Feta nant at time of t		3 ∐Ectopic 5 ☐ Other	pregnancy (specify)				Mont			ear
	P.O.	at the by th	hys	9 Unknown		9□ Unkn											
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	oro	nequii	Completed	H15T0	sry of	SW	ellowin	9 0	ti sor	-der			1 🗆 Yes	2 🗆 No 3	Proba	ibly 4 Un	nknown
	ec	elaw hesb e2sl	nple									_ 24	a. Was an autopsy	pri	or to com	sy findings av	vailable use of
	E	cate pag	S									1[performe □Yes 2		ath?]Yes	No	,
	Zi.	siciar certif recto	Be	25. Was case referred examiner?	to medical	Hospital:		ā		Othe	26. Place of [
	of	Phys rthis raldi	.T	1 Yes 2 No 27. Manner of Death		101			atient 3	DUA	4 LI Nursin			e 6 Other)	
	on .	th: Atte	盲	1 Natural 5	Pending investigation	- Jan 3	of Injury th, Day Year)	4	PM SM	Work		104	V- £	C.	1		
	Division of Vital Records,	Atter	ertification:		Could not be determined	286. Place	of Injury - At h	ome, farm	**	ory, office	/ \	28f. Lo	cation (Street	et and Number	or Rural	Route Numbe	er,
		talor satte al Dir ed in	Cert	4 Tromicido		buildi	ing, etc. (Speci	iy)					ty or Town, s	Wash	nato	n Rd	
		To the Hospital or Attending Physician: The law requires that the death certit within 24 hours atter death. To the Funcaral Director: After this centificate has been signed by the attending completely tilled in by the tuneral director, page 2 should be detached for use as	cal	29a. Certifier	Certifying Ph	ysician: To the	best of my kn	owledge, o	death occurre	ed at the tim	e, date and pla	ace, and du	e to the caus	se(s) and man	ner as sta	ited.	
	;	the hin 24 the F	Medi	one)		and man	ner stated.	ation and				conied at ti					
		To viti	~	29b. Signature and title	or certifier	7			į	29c. License				Date signed			
	,	~) f	() (d	ral he	yern	M			1005	5849		Fe	bruary	28	2008	-
	In	+1		30. Name and address		71	11	m 23a) (Ty - /_ /	ype, Print)	11	A	10	1./ 5	bruary re Mo) S	1	
	W	Sta	te_	31. Date filed (Month, I	Day, Year)	32.R	5 /70 80 / legistrar's sign	ature	900	(c/on	men re	159	/TIMO	re /VIC	aryl	ny	
		Registr	300	MA	R 1 0 21	J08 A	1818 D	All I	Sicorde.	P							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2.28AM 2000 Mary Margaret Kamerman /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital Silver Springs Montgomery | B. Date of Birth | 9. Birthplace (Security) | 19. Birthp 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🙀 F 65 Yrs. Director 008-30-1741 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If itam 27 Is marked other than "natural," or Itams 23a or 28e-f show 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County the profit of the profit of the 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5778 Flag Flower Place 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: other traumatic evant, the Mudicul Exar 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16a. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Howard County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Guidance Counselor Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h James Eisbrenner Pearl Sherman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel S, Kamerman 5778 Flag Flower Place Columbia, MD 21045 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 03/07/2008 * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 22. Name and Address of Facility
Witzke Funeral Homes, 21. Sign ture of Funeral Service Licenses Inc. 10/203 5555 Twin Knolls Road Columbia, MD 21045 23a. Part. Enter the disease or complications that caused the death. shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, ATHEROSCHEROTI EREBROVASCULA **Physician** 15 A95G disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No al director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☑ No Certification: To 3100A 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation s after death the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

tha

Baltimore, Maryland 21215-0036

P.O. Box 68760,

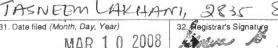
Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year) 2008 10

suelli

29b. Signature and title of certifier



ollram

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

28595

SUITE

20

29d. Date signed (Month, Day, Year)

			Plea	se Type or Pri									_		
			For	State of Ma	arylan					id Mer	,	•	000	0 (17500
		_	State Registrar 1. Decedent's Name (First, Middle	- (ont)		Ce	ertifica	ite of l	Jeath	2	Date of De	Reg. No.	200	0 1	Time of Death
F	Physicia /Medic	16	Beatrice,		T/21e	9					Month	Day 3	Yes 200	ar	16.26 PM
	Examin	er	4a. Facility Name (If not institution Howard County			el	4b. Cit		Location of E			4c.	HOW	//	1
	Funeral		5. Social Security Number			last birthday		er 1 Year	If Under 24	Hrs. 8.	Date of Bir	th		Birthplace	(State or Foreign
i.	Director		215-12-5698 Usual Residence of Decedent	1□M 2⊠F 89)	Yrs.	Month	s Days	Hours	Min. Se	(Month, Da pt 15	, 19	18 We	Country)	irginia
	yland how at		10a. State 10b. County			y, Town or L									nside City Limits
	Ba-f s	Director	Maryland Howar	d	E11	icott									☐Yes 2 🖾 No
	with the		10e. Street and Number					Zip Code				_	zen of What USA	Country?	
	ns 23	Funeral	9309 Ramsey Dri	12. Was Decedent	Ever in U.	.S. 13.		.042 cedent of H	ispanic Origin an, Mexican, F	? (Specify	/ Yes or No		14. Race - A		dian,
036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:				ecify Cuba	n, Mexican, F Specify:	ouerto Ric	an, etc.)		Black, W Specify:	/hite, etc. Whi	te
2-0	72 ho 'natur dical	eted	15. Deceden (Specify only higher	t's Education st grade completed)		16a. Dece	edent's Us	sual Occup	ation during most of f)	f working		16b. Ki	nd of Busine	ss/Industr	/
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	1			" v Speci		t	Soci	al Se	curit	y Adm.
Baltimore, Maryland 21215-0036	should be filed vind Mental Hygie marked other timatic event, th	Be Co	17. Father's Name (First, Middle,	Last)		Quera	 -		18. Mother's	Name (F	irst, Middle	, Maiden	Surname)		
<u> </u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any Injury or other traumatic e once.	ဥ	Harrison Mortor 19a. Informant's Name/Relations		nora	10h Mail	ling Addro	es (Stroot	and Number of			ner City o	r Town Stat	a Zin Cod	
<u> </u>	nd 2 sl Ith an 27 is r traur		Mary Spence	Daughter		1	•	,	oad; Ca					. ,	6)
re,	is 1 and of Health Item 27 other to		20a. Method of Disposition			Place of Disp cemetery, cre	osition (N	ame of	e)	Date)	20c. Lo	cation - City	or Town,	
<u>E</u>	Pages nent of i		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (S			etro C	remai	tory	03						aryland
Salt	permit. Departr Importa any inju		21. Signature of Lineral Service	ticepsee	10.00	2)	22. Name	and Addre	ss of Facility	Sterl Cato	ing A	Ashto 11e.	n Sch Inc.	wab W	itzke
	90 E # 0	31 1	CY F	complications that aures	10127	Do not or	1630	Edmo	ome of	Avenu	ie: Ča	atons	sville		
ch	Dhaminina		23a. Part1. Enter the disease, or shock, or havert failure. List Immediate Cause (Final			ding	iter the m	ode or dyll	ig, such as ca	ildiac of re	sapiratory c	11031,		Inte	oroximate rval Between set and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to for an		uanna of)ı	-		`						
6.	Examiner		Sequentially list conditions	p. Pulm	onar	y ky	serle	nsio	1						
٠.	BIV #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence or):									
	be executed sician and burial-transit	Examiner	resulting in death) Last												
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89	tificat ng phy as the	Nedic	15 55444 5												
30 20	death certificate b attending physic	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 ☐ Feta	al death 3		pregnancy	,				23d. Date of Month	delivery Day	Year
0	he deg	ysici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	leath 5	Other	(specify)							
Vital Records, P.O. Box	The law requires that the death certificate are has been signed by the attending physage 2 should be detached for use as the		Part II. Other significant condition	ons contributing to death t	out not res	ulting in the	underlying	g cause giv	en in Part I.		23e. Did	tobacco	use contribut	e to the ca	use of death?
rds	equires en sign vuld be	ed by								_	1 🗆	Yes 2	□ No 3□] Probably	4 🗷 Unknown
ပ္ပ	re law re has be ye 2 sho	Completed								[24a. Was	psy	prior	to comple	findings available tion of cause of
<u>س</u>	The cate h	Соп									perf 1∑ Yes	ormed? 2□ No	deat		No
Z Z	sician certifi rector	Be	25. Was case referred to medica examiner?	Hospital:		IED/O 14/-		DOA Oth	26. Place of	,					
ō	y Phys er this eral dii	T0	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju	ury	28b. Time	of	28c. Injur Wor	4 LI Nursi				6 □Other (Specify)	
lo	ath. rr: Afte	atior	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	ay rear)	Injury	М		K? Yes 2 □ No)					
Division or	or Attending Physician: The after death. Director: After this certificate he in by the funeral director, page	Certification:	3 Suicide 6 Could 4 Homicide determ		jury - At h tc. <i>(Specil</i>	ome, farm, s	street, fact	ory, office		28f.	Location of City or To	(Street ar own, State	nd Number o	r Rural Ro	ute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p			ng Physician: To the best Examiner: On the basis of											
	To the H within 24 To the F complete	Medical	one)												
	5 W TO TO TO	2	29b. Signature and title of certifie	Hunad ,	M-D			2) Licens	/ m 2 i	v C		290. D8	ve signed (N	юпип, <i>D</i> ay,	2008
)			30. Name and address of person	who completed cause of	death /Iten	n 23a) (Tyre	a. Print)	000	600	7 5		7,0	,	,	_
	10		Kaisez Aim.	ad 10724,	little	Pat	LLEXC	nt 1	Parkwo	y	Colu	mbre	210	44.	
	Sta Registi		31. Date filed (Month, Day, Year)	2008 32 Regist	rars Sign	шие	Nan Bran								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 **Physician** March 7, 11:59 A^M John Vernon Kropi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore <u>Cockeysville</u> Maryland Masonic Home Birthplace (State or Foreign Country) ear If Under 24 Hrs. 7. Age (In vrs. last birthday 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 □ F Director Maryland 96 10/18/11 215-18-5694 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 XYes 2 No Director MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21211 USA Funeral 4431 Beuna Vista Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify þ Year or Dates: 1943-45 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) q <u>Salesman</u> Jewelry If item 27 is marked other or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Ethel Pannell Pages 1 and 2 should nent of Health and Men John Kropf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Mrs. Joyce E. Scarcella</u> 107 Roundup Road Middle River, Md. 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department or Important: If any injury or once. Loudon Park Cemetery 3/12/08 BALTIMORE, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, of shock, or heart failure. List emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepano **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) burialattending physician Physician/Medical ass IF FEMALE: esn If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 XNo 24a. Was an has page 2 autopsy perform certificate BP Deneita 25. Was case refe red to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certification: After Hospital or Attending 5 Pending investigation 1 Natural after death. 2 Accident

P.O. Box 68760, Records, Division or Vital

(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	· I		28c. Injury at Work? 1 ☐ Yes	М	tnjury	28a. Date of Injury (Month, Day Year)	
--------------------------------------------------	-----	--	------------------------------------	---	--------	------------------------------------------	--

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Į	29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occu Medical Examiner: On the basis of examination and/or investigand manner stated.		
	29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

7/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

Bowh Sit 3208 31. Date filed (Month, Day, Year) 32. Registrar's Signature 0

State Registrar

5+1

24 hours after deate Funeral Director:

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filled

npletely within 2 the

Medical

3 ☐ Suicide

4 THomicide

Medical Certification: To Be Completed by Physician/Medical Examiner

12:25 а.ш.

MARCH 6, 2008

AUDREY KANE

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

State of Maryl	and / Depa	artment (of Health	and M		_	
1 - State Registrar	Cei	rtificate	of Deati	h		1. No. 4 U	07590
1. Decedent's Name (First, Middle, Last)					Date of Death Month		3. Time of Death
Audrey Eleanor Kane					March 6,		12:25 A M
4a. Facility Name (If not institution, give street and number)			wn, or Location	n of Death		4c. County of	timore
Stella Maris 5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 '		er 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
212-34-7410 ^{1□M 2} ØF	76 Yrs.	Months D	Days Hours	Min.	(Month, Day,) 8/4/31	/ear)	Country) Maryland
Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation					10d. Inside City Limits
MD n/a	Ra1	timore					1 XYes 2 No
10e. Street and Number	2011	10f. Zip Co			100	g. Citizen of Wh	nat Country?
1313 Hull Street			21230			USA	Α
11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Deceder If Yes, specify	nt of Hispanic (Cuban, Mexic	Origin? (Sp	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 2				Specify:	White
15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual (Occupation	ast of work	ing 16	6b. Kind of Busi	iness/Industry
Elementary/Secondary (0-12) College (1-4or 5+)			done during m retired)	LUI DI WOIN		_	
9	0	wner	16.11	thor's N'	o (Eirot 1117-11- 11	Store	
17. Father's Name (First, Middle, Last)			18. Mo		e (First, Middle, Ma		"
John Loose 19a. Informant's Name/Relationship (Type. Print)	10h Maili	an Address (f	Street and No		ie Stumpf al Route Number,		State Zin Code)
, , , , ,					re, Maryl		
Mr. James T. Kane, Jr.	b. Place of Dispo cemetery, crei						City or Town, State
Bunai 2 Ucremation 3 Hernoval from State	cemetery, crei Loudon P	matory or other ark Ce	_{erplace)} meterv	3/8	/08 .		16 1 1
4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Address of Fac		oudon Par		re, Maryland
The same of the sa	'			. Ъ			land 21229
23a. Part1. Ef er the disea er complications that caused the c shock, heart failurs. List only one cause on each line.							Approximate
Immediate Cause (Final							Interval Between Onset and Death
disease or condition resulting in death) a. OVARIAN CA							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):						
that initiated events							
resulting in death) Last Due to (or as a con	isequence of):						
d							
IF FEMALE: 23c. If yes, outcome pf pro	agnaney					00 L D.L	
in the past 12 months?	Fetal death 3	⊒Ectopic preg ⊒ Other (spec				Moni	of delivery th Day Year
1 ☐ Yes 2 🛣 No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	ordeath 5L		y)				
Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cau	se given in Pa	rt I.	23e. Did toba	acco use contrib	bute to the cause of death?
					1 ☐ Yes	s 2□ No 3	3 ☐ Probably 4 K Unknown
					24a. Was an	24b. W	ere autopsy findings available rior to completion of cause of
					autopsy	ed? de	eath?
25. Was case referred to medical			26. Pla	ace of Deat	1 Yes 2 th (Check only one	A	□Yes 2□No
examiner?	2 ☐ ER/Outpatie	nt 3 DOA	- Cultural				r (Specify) HOSPICE
27. Manner of Death 28a. Date of Injury	28b. Time c		c. Injury at Work?		28d. Describe how		
2 Accident investigation	, ,,,,,,,	М	1 ☐ Yes 2	□No			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - / building, etc. (Sp	At home, farm, st pecify)	reet, factory, o	office		28f. Location (Stre City or Town,	eet and Numbe State)	r or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.							
29b. Signature and title of confifer		29c. l	License numbe		29		(Month, Day, Year)
1-			1437 2	5		3161	08
30. Name and address of person who completed cause of death DR. TARIQ MAHMOOD 2300 DULAN			TIMON	IIUM.	MD 21093		
31. Date filed (Month, Day, Year) Registrar's S	Sanatura #						
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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** Lillie 2008 Koolin 04 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner General Auspital Mentgomes Montgomery If Under 1 Year | Winder 24 Hrs. Birthplace Country) 8. Date of Birth (Month) Day, Y 6. Sex 7. Age (In yrs. last birthday State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min. 1 M 2 X F MD Q18-05-629 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If them 27 is marked other than "natural" or theme one traumestra 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County MD MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14508 HOME CREST ROAD, #311 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No WHITE Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HYMAN COHEN REBECCA SIEGEL ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14410 PECAN DRIVE, JANET GENSLER / DAUGHTER ROCKVILLE, MD 20b. Place of Disposition (Name of ARCEINGTON Comparatory or other place) CHIZUK AMUNO 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/07/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or 's a convequence of): disease or condition resulting in death) /Medical Examiner Phennia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐NO the detached 9☐Unknown 9 ☐ Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? 1∐ Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours a er death. To the Funeral Director: After Injury 1 DNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a, Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 296. Signature and title of certific 18212000 2008 MD 30. If e and address of person who completed cause of death (Item 23a) (Type, Print) Prive, olnen D. Kirkcaldy 18101 31. Date filed (Month, Day, Year) MAR 1 0 2008 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Eileen Helen Lorenzini February 29, 2008 9:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Transitions Health Care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 ⋤ F 88 203-05-1450 24,1919 Pennsylvania Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard EllicottCity 1⊠Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3100 N. Ridge Road 21043 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 25 No f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 XNo Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Processing U.S. government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Reagan Alexander MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Grennon/Niece 67 Curzon Mill Rd., NewburyportMA01950 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 11 1 Burial 2 Cremation 3 Removal from State Hanover Township, PA St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Rendon-Bailey Funeral Home, P.A. 21. Signature of Funeral Service Licensee WI /M00969 2818 E. Baltimore Street, Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerone Cardo vascular Due to (or as a consequence of) nertengion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ZINo Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 TYes 2 No 3 Probably 4 Dinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2QNo 25. Was case referred to medical 26. Place of Death | Check only one | examiner? Hospital: 1 Inpatient Other: 4 Surrsing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 25LNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Anatural 5 Pending М 1 ☐Yes 2 ☐No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: death. within 24 hours after death To the Funaral Director: e u

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ortant: if itam 27 ie marked other than "natural; or items 23a or 28a-1 ehow injury or other traumatic event, the Medical Examinar must be notified at

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Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of pertifier

1ATZ 1 Q MA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MAHMOUD

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	iryland		artment o <i>rtificate d</i>			lental H	ygiene Reg. No	7 0 0	8	07593	3
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1270	Funeral		5. Social Security Num			(In yrs. last	t birthday)	If Under 1 Y	ear If Und	ler 24 Hrs.	8. Date of E	lirth	T q		ace (State or Foreign ry)	_
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permit.	Department of Important; If any Injury or once.		21. Signature of Fund	eral/Service Licen	MUZ34		F	2. Name and A leck Fund 501 Sand	ral Hor	me, INC		MD 20	1707			
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	/Medic	cal Alpha Omega Larkins						March 4			7:30 P M	
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<u>ν</u>	ss 1 a of He item			lace of Dispo	sition (Name of matory or other place	ce)		Date	20c. Location	on - City or To	wn, State	
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Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funghal Service Licensee MO(234)		Name and Addre				MD 2070	7		
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9	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome pf pregna	ancv	***				224	Date of delive	200	
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	the H iin 24 the Fi tplete	Medical	one) and manner stated.	on and/or m				ou at the time,				
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1	4		30. Name and address of person who completed cause of death (Iter Syed Saddiq, MD 14333 Laurel Bowie R			8						
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			1 - State of Maryland / Department of Health Certificate of Deat			giene Reg. No.	008	07595
76	° Physici /Medic		1. Decedent's Name (First, Middle, Last) $B \in SS : \in Linzer$		2. Date of Dea Month	ath Day	Year 2008	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Ridgeway Manor Nursing Home Baltimore				unty of Death	1
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours 89 Yrs.	er 24 Hrs.	8. Date of Birt (Month, Da May 1	y, Year)	Cou	nplace (State or Foreign untry) aryland
	ryland how	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	h the Ma r 28a-f a	Director	MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code			10g. Citizen	of What Cou	1 ☐ Yes 2 反 No untry?
	23s c	raiD	304 Cantata Court 21136			U.S.A	1.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Important: If item 27 Ia marked othar than "natural", or Items 23s or 28a-f ahow any injury or othar traumatic evant. The Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Never Married 2 Married 1 Yes, Give Year or Dates: 1 Nas Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates: 1 Yes 2 No Special		cify Yes or No Rican, etc.)		Race - Amer Black, White ecify:	
21215-0036	iithin 72 ho ne. han "natur: Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)	ost of worki	ng	16b. Kind o	of Business/I	
	iled w Hygiei thar tl		12 Security Manager 17. Father's Name (First, Middle, Last) 18. Mol		(First, Middle,		stingh	ouse
Maryland	uld be 1 lental 1 rked o	To Be		Franc		udrna	nume)	
lary	2 shou and M la mai		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	nber or Rura	l Route Numbe	er, City or To	wn, State, Z	ip Code)
	os 1 and of Health itam 27 other tr		Marlene T Glaeser Daughter 4034 Wards Chape 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Marr		ville, on - City or T	
ш	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser	. 3/8	/08	Hamps	stead.	MD
Baltimore,	Depart Depart Import any inj		21. Signatury of Funeral Savice Licensee 22. Name and Address of Fac	. 11	824 Re			
	* .		ELINE FUNERAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a				MD :	21136 Approximate
	Physician		shock, or heart failure. List only one caus on each line. Immediate Cause (Final disease or condition A Yeary D	riteer	4			Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):					7 %
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury					
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9	ertifica Jing ph ie as th	Med	IF FEMALE:					
D. Box	e de th certific the altending p ned fir use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)				Date of delivery	
, P.O.	ires that the de signed by the a d be detached t	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I.	23e. Did to	bacco use o	contribute to	the cause of death?
rds	w requires been sign should be		Chrenic leidney biseens		1 🗆 Y	′es 2□N	o 3∏ Pro	bably 4 dinknown
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Vita		Bec		ace of Death	(Check only o			
	> 50 0	٥	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		ne 5 🗆 Resid			ify)
on	th. : After s funer	rtion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? M 1 Yes 2		.od. Describe i	low injury oc	curred	
Division of	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	2	88f. Location (S City or Tow	Street and Nu m, State)	umber or Rui	ral Route Number,
	To tha Hospital or within 24 hours after To tha Funaral Dirticompletely filled in I	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.	and place, a leath occurre	and due to the o	cause(s) and date and plac	manner as	stated. to the cause(s)
ı	To th withir To th comp	Me	29b. Signature and title of certifier After and 29c. License number 0369	42		29d. Date sig	gned (Month	Day, Year)
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TWAKNA, MD 1009, Frederick Rd.	Ca to	more	, M	0 2/2	28
	Sta Registr	100	31. Date filed (Month, Day, Year) MAR 1 0 2008 32. Registrar's Signature.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 2, 7:15 p M 2008 Ronald James Lettau 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice **Baltimore** N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min Months Days Hours 13K M 2 □ F 215-42-0783 66 31, 1941 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits Maryland Howard Elkridge 1 □Yes 21X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7160 Millbury Ct. 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) NTYes 2 No If Yes, Give Year or Dates: Peacetime 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Brush Company Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Haro1d The 1ma Keffer Lettau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Penenburgh (Daughter) 7160 Millbury Ct., Elkridge, MD 21075 20h. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Balcemetery crematory or other place! Balcimore Crematory C Loudon Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nepatocellular carcinoma 2 years Due to (as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760. the P.O. by the a signed b Records, peen has page certificate Division or Vital After thi

Physician

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Medical Certification:

29a. Certifier

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

72 hours

2 should be filed within and Mental Hygiene.

Is marked

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trat once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Lettan

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: completely filled in by the f To the within 24

State Registrar

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

March 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice 835 1 32. Registrar's Signature 838 N. EutawSt Baltimore

31. Date filed (Month, Day, Year) MAR 1 0 2008





and manner stated.

			1- For State Registrar Amend 19a, per	State of Maryland		nent of H	ealth and N Death		giene () ()	8 07597						
*	Physic /Medi		1. Despedent's Name (First, Middle, Las.					2. Date of De		Year 3. Time of Death	V					
	Examination Funeral Director			of tuntin	chaute 1	GHm Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb. 14,	y, Year)	of Death 9. Birthplace (State or Foreign Country) MD	חק					
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	th with the 23a or 28	Funeral Director	10e. Street and Number 1637 Fulton Avenue		101	f. Zip Code	21217		10g. Citizen of W USA	hat Country?						
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-1 show or other treumatic event, the Medical Examinar must be multiled at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes,	Decedent of His specify Cubar es 2 M No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	- 14. Race Black Specify:	- American Indian, s, White, etc. Black						
21215-0036	within 72 h ene. than "natu the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Decedent's (Give kind o life. DO NO	Usual Occupa of work done d OT use retired) teacher	furing most of work		16b. Kind of Bus Baltimore	city School Syst	en:					
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lary	2 should and Men is marks eumatic		19a. Informant's Name/Relationship (T)	vpe, Print)			and Number or Rui			State, Zip Code)	_					
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altir	permit. P Depertme Importan eny injur.		21. Signature of Funeral Service Licens		inity Cemet 22. Nam		03/07/ s of Facility Wy		Baltimore,							
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<u>α</u>	es the igned be de	by	by	by	Part II. Other significant conditions co	n in Part I.	23e. Did to		oute to the cause of death? B Probably 4 Unknown	1						
I Reco	The ate h page	Completed						24a. Was a autop perfor	sy pr med? de	ere autopsy findings available for to completion of cause of sath? Yes 2 \sum No)					
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat		ле)							
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Divis	al or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, fa	ctory, office		28f. Location (S City or Tow		r or Rural Route Number,						
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death occur on and/or investiga	rred at the time ation, in my opi	e, date and place, inion, death occur	and due to the cred at the time, o	ause(s) and man date and place, ar	ner as stated. nd due to the cause(s)						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	- 2	9d. Date signed	(Month, Day, Year)						
,			PON	[1		51	7202	,	3/5	08						
			30. Name and address of person who co	ompleted cause of death (Item:	23a) (Type, Print)	D		<i>-</i>	. /	Aug Dig						
- W	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	4 AVA	BAL	TIMOR	E M	0, 21.	121	-					
1	Registr	ar	MAR 0 7 2006	A A	and the											

DHMH 17 Rev 1/2001

amend item 18 per fb 9877 3-10-08 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death me (First, Middle, Last) 2. Date of Death Physician 2008 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner timer Under 1 Year If Under 24 H 8. Date of Birth (Month, Day, 09. 07. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 9 1 ☐ M 2 🔽 F Director filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or ar traumatic event, the Medical Examiner must be in 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: sian Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. POPOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5: cian permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othvany injury or other traumatic event, Name (First, Middle, Father's Name (First, Middle, Last, Be 19b. Mailing Address (Street and Number or Rural Route Number, Method of Disposition

1 □ Burial 2 ▼ Cremation 3 □ R

4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execute and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1□ ¥es 2□ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 8 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 4 Unknown icate has been sig r, page 2 should b 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an autopsy performed? /es 2 \(\square\) No certificate 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 3□ DOA 2 ER/Outpatient Medical Certification: To this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in any anti-type time. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature any 30. Name and ess of person who completed cause of death (Item 23a) (Type, Print 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fib 8877 3-10-08 to State of Maryland Abepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Matthews March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year If Under 24 Hrs. Baltimore
5. Social Security Number Medical Age (In yrs. last birthday, 76 Yrs. If Under 1 Months 9. Birthplace (State or Foreign Country) 1 2 date of Birth 12 dont 2 9 ay, Year) **Funeral** 1**№**M 2□ F Days Hours 240.42.3671 NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director ЛD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? redcrest 5202 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Irail ways College (1-4or 5+) Bus 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Matthews anie 9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ra. Balto Son) William 5202 1atthews Ma. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, and 3.11.08 4 ☐ Donation 5 ☐ Other (Specify) parvison torest Name and Address of Facility Vaughn Creene 21. Signature of Funeral Service Licensee Balto Md. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of): **Examiner** Failure enal Sequentially list conditions, if any serious immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cardiomyopathi page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate has To the Hospital or Attending Physician: within 24 hours -fter death.

To the Funeral Director: After this certifica After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide filler 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU4176435 W17471 March MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Baltimore MD Wermine \$2. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 0 State Source ! 2008 1000

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month Physician March 4, 11:50 A M Moore James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle River Baltimore 3504 Bay Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 19 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 89 705-12-5734 **Director** Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Middle River 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3504 Bay Drive 21 220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner ma 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WW II 1 ☐ Yes 2 🛣 No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Electric Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h John A. Moore Mary Duban ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mildred Moore (spouse) 3504 Bay Drive, Middle River, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/08/2008 Gardens of Faith Baltimore, Maryland 4 Don#tion 5 Other (Specify) 21. Signatur of Fanerai 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or conshock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death 2 WECK Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 200 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2000 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 No 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-4-2008 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911/4 Philadelphia RD. Suite 300 BACTO MD 2123-) 32 Registrar's Signatule State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2008 Clare M. Mosmiller March 6, 5:11 Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore 709 Hidden Bluff Circle If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 🛣 F Yrs. 70 Aug. 10, 1937 Director 212-34-7849 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 709 Hidden Bluff Circle 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 2 Specify. 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ot Obal Synan Mary Yates 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health al
Important: If item 27 is
any injury or other trans Husband Joseph W. Mosmiller 709 Hidden Bluff Circle; Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 3/11/2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fundal Service Mo/290 Funeral Home of Catomsville, Inc. 1630 Edmondson Avenue; Catomsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) entemi Levelo canoris **Physician** year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selectionesquence off Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ρ in the past 12 months? 1☐Yes 2★No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home Hospital: 3□ DOA 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 5 Residence 6 □Other (Specify) Certification: To this . Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimmel Cactr. @ Johns Hopkins Baltimore MD 32. Hegistrar's Signat

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07602 1 - For State Registrar Certificate of Death Reg. No:-3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Katherine 7:19 p M Mann 2008 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1231 Wine Spring Lane Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV . 8 1917 5. Social Security Number 9. Birthplace (State or Foreign Mary land Months 1 □ M 2 🕱 F Davs Hours Min. 90 215-10-1968 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Md. Baltimore Towson 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 1231 Wine Spring Lane Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 🗶 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Specify Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Mary Streviq မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Cortez Ave. Vista, Ca. 92084 Mr. Richard Maglidt/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ XOther (Specify Intombment Dulaney Valley Mem. 3-10-08 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Furieral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a forsequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 ☐ Unknown Completed by Be

Physician /Medical Examiner requires that the death certificate be executed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

and burial-transit physician as the l signed by the attending I be detached for use as cate has been sig page 2 should b

Division or Vital Records, P.O. Box 68760,

Certification: To

funeral director,

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Part II. Other significant conditions	ontributing to death but not result	e given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow					
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 😿 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	28b. Time of Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)		ffice	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ysician: To the best of my know							

29c. License number

D20649

6701 N. Charles St. Towson, Md. 21204

29d. Date signed (Month, Day, Year)

2008

State Registrar

Medical

John W. Bowie, MD 31. Date filed (Month, Day, Year)

MAR 1 0

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar		artment of Health and rtificate of Death	Mental Hygiei	ne2008 07603
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
d.	/Medic	_	ALICE M. MERSHON		45 Gir Town and analysis of G	MARCH 6	2008 6:00 A. M
	Examin	er	4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Dea	ith	91
	Funeral	1	GLEN MEADOW RETIREM 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	GLEN ARM If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	BALTIMORE 9. Birthplace (State or Foreign
	Director		219-30-4851	201F 99 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Ye 3/4/1909	PENNSYLVANIA
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryli f sho	ō	MD BALTIMORE	GLEN AF			1 ☐ Yes 2 🕱 No
	r 28e	rect	10e. Street and Number	ODEN AL	10f. Zip Code	10g.	Citizen of What Country?
	h with	Funeral Director	11630 GLEN ARM ROAD	APT. 108	21057		USA
	ems (ıner	A	Vas Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin?	Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs after death with the Marylar ', or Items 23e or 28e-f show Ranifier oust be notified at	by F.	If	☐ Yes 2 ☑ No Yes, Give 'ear or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: WHITE
5-0036	72 hours netural', dical Ex:	ted t	15. Decedent's Education	n 16a Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
212	within 72 hours after death with the Maryland ene. Than "netural", or Items 23e or 28e-f show Ite Mcdical Examiner i ust be notified at	Completed	(Specify only highest grade con	college (1-4or 5+) (Give life.	kind of work done during most of w DO NOT use retired)	onking	
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and	€ d ia b	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maio	en Sumame)
Maryland 21	d 2 should by the and Menta 7 is marked treumatic events	ဥ	EDWARD ACKER 19a. Informant's Name/Relationship (Type, F	Print) 19b. Maili	JESSJ ng Address (Street and Number or I	E WORDEN Rural Route Number, Ci	ry or Town, State, Zip Code)
	12 har	1 8	BARBARA REED/DAUGHT	6900	GLEN KEITH BLV		MO 21286
Baltimore,	- I 5 =	T.	20a. Method of Disposition	20b. Place of Dispo			Location - City or Town, State
Ē	Pages nent of ent: If it ury or o	٠,	1 ☑XBurial 2 ☐ Cremation 3 ☐ Removed 4 ☐ Donation 5 ☐ Other (Specify)	vai from State	1	13/2008 PA	ARKVILLE, MD
3alt	permit. Pag Department Importent: I eny Injury o		21. Signature of Funeral Service Licensee				FUNERAL HOME, P.A.
	<u> </u>		23a. Part1. Enter the disease, or complication		3521 LOCH RAVEN E		DN, MD 21286 Approximate
		-	shock, or heart failure. List only one ca	use on each line.			Interval Between Onset and Death
	1 ysician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	rds vaseular	avience	years
	Examiner		Commentation that are distance				
./	בי פ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
9	certificate be executed iding physician and ise as the burial-transit	Examiner	that initiated events c	Due to (or as a consequence of):			
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687	ificate g phys	edicai	0.				
Вох	eath certific attending p	Physician/Me	23b. was decedent pregnant	yes, outcome of pregnancy □Live birth 2 □ Fetal death 3[∃Ectopic pregnancy		23d. Date of delivery
	0 0 0	sicia	1 Yes 2 No		Other (specify)		Month Day Year
o.	ires that the de signed by the a I be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions contribu		underlying cause given in Part I	23e Did tobace	co use contribute to the cause of death?
ds,	law requires that the as been signed by th 2 should be detache	d by	Decusitus well	thing to death but not resulting in the t	inderlying cause given in vario.	1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Records,	v require been sig should b	Completed by	Hy sertensian		······································	24a. Was an	24b. Were autopsy findings available
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ta	iicl en: Th certificate rector, pag	a)	25. Was case referred to medical		26. Place of D	eath (Check only one)	NO 10163 2010
	Physicien: r this certifica ral director, p	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	tal: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
Division of	ding Pt n. After th funeral		1 Latural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how i	njury occurred
	Attending Physicien: If death. Sector: After this certification by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Be. Place of Injury - At home, farm, st	M 1 Tyes 2 No	28f Location (Stree	t and Number or Rural Route Number,
=	after after Direction by	ertif	4 Homicide determined	building, etc. (Specify)	iost, ractory, othor	City or Town, S	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physicie	n: To the best of my knowledge, deat	h occurred at the time, date and pla	ce, and due to the caus	e(s) and manner as stated.
	the Ho	ledical	one)	On the basis of examination and/or in and manner stated.			
	To with	Σ	29b. Signature and title of certifier	My mo	29c. License number	29d.	Date signed (Month, Day, Year)
	, 2		70001000		D J V 7 J J		
	10		30. Name and address of person who comple	ted cause of death (Item 23a) (Type)	s Du Ballin	nove Md	2008 21204
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	each)		
	Registr	ar	MAK I U ZUUS	The Market See Jay	100		

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 29 Day 2008 **Physician** 11:55 P M ORNDORFF SAGER ELNORA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince Georges If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Sept. 5, 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 🕸 🗆 F 234-46-7008 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Laure 1 Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724 USA 58 Bruce Street. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Moyer Perry Franklin Sager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Sullivan- daughter 1336 Greywood Rd., Odenton, MD 21113 Pages 1 ent of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 3/6/08 Brentwood, Maryland 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility
Fleck Funeral Home, INC. 21. Signature of Fur eral Service Licensee MO123 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio-Respiratory Failure /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Malnutrition the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Diabetes Mellitus Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 Tes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita Shaw, MD 7300 Van Dusen Rd., LAurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

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2008

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2/239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Peaks 6:04 AM Ermest March 3 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cut Mercy Medical Conter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Days Months Hours 218-46-9026 Director 1 au Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10b. County 10d. Inside City Limits 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Ma 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, item permit. Pages Department of Important: If it any injury or o ₩ Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) e of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) infection Physician Staphlococcus aureus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, france, leading to himself to cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Division or Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed Was al. autopsy performed? Yas 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director: A 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/3/08 Shouti Keepoor P 22 083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Karpoor

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

32 Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Ling Li, MD

31. Date filed (Month, Day, Year)

MAR

Assistant Medical Examiner

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Division or Vital Records, P.O. Box 68760.

State Registrar DHMH 17 Rev 1/2001 MITH

W. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN HOPKING HOSCITAL

145-000

2128

Specimons

Box 68760. Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

certificate be executed

within 24 hours after death. To the Funeral Director: After Hospital or Attending completely filled in by the the

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State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore Maryland 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beame

and manner stated

Hopkins Bayview Circle

31. Date filed (Month, Day, Year) 0 32, Registrar's Signature 1800130

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1000

			1 - For State Registrar	State of Maryland	Certificate of			enez () () ()	07610
	Physici		1. Decedent's Name (First, Middle, Last, Stark 0.5 V.	PlagiANak	08		2. Date of Death Month		3. Time of Death
9	/Medic Examin Funeral Director		4a. Facility Name (II not institution, give Har Ford Men 5. Social Security Number 6. Sec. 15	street and number)	tal Havre	or Location of Death De GTRA If Under 24 Hrs. Hours Min.		4c. County of Death HAR FO. Year) 9. Birth	Rd place (State or Foreign intry) 1RECCE
	death with the Maryland ms 23a or 28a-f show finant be codified at	tor	Usual Residence of Decedent 10a. State 10b. County Hart	lord Da	Town or Location				10d. Inside City Limits 1 Yes 2 No
*	death with the Maryla The 23a or 28a-f shov	Funeral Director	10e. Street and Number	Ne Court	10f. Zip Code 2/0	34	10	g. Citizen of What Cou	,
14 CM		by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs 1 □ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0	d within 72 hours after giene. sr than "natural", or ite the Madical Examine	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of worki	tor.	6b. Kind of Business/Ir Pavina Co	onstruction
Maryland	s 1 and 2 should be filed within I Health and Mentat Hygiene. Item 27 is marked other than other traumatic event, tha M	To Be C	17. Father's Name (First, Middle, Last) Vasi // 03 Plage 19a. Informant's Name/Relationship Ty	ANAKUS	19b. Mailing Address (Street	18. Mother's Name	A GIRI	GORAKIS	n Code)
Plear.	Pages 1 and 2 s ment of Health ar ant: if item 27 is ury or other trau		ANASTABLA KILLAN 20a. Method of Disposition 1 Paurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Plac	e of Disposition (Name of etery, crematory or other place)	ve Ct, Z	arlingt	/	1034
Balt	permit. Departr Imports eny inj		21. Signature of Funeral Service Licens)	Home, PA	2134 W	Villow &	ASNON F	1,21222
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	touti curci touti curci schemic so	ulation	and	brun-	Approximate Interval Between Oneet and Death
68760,	ificete be executed g physician and Kasas the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer CLUM Due to (or as a consequer ASSIGNATION DUE TO (or as a consequer)	nce of):	occli	won		Days-1/2
Вох		Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 Ectopic pregnancy	,		23d. Date of deliv Month	rery Day Year
ords, P	v requires that the been signed by should be detact	ed by Pt	Part II. Other significant conditions cor	ntributing to death but not esulting	ng in the underlying cause of	en in Part I.	23e. Did toba	acco use contribute to t	
tal Reco	iician: The law re certificate has be rector, page 2 sho	au l	Chronic No Droboble 25. Was case referred to medical	pertension Stabetes	Wellstein	26. Place of Death	24a. Was an autopsy perform	No 1 Yes	opsy findings available ompletion of cause of 2000
Division of Vital Records, P.O	ding Phys h. After this funeral di	ation: To B	examiner?		Oth	er: 4 🗆 Nursing Ho		nce 6 □Other (Speci	fy)
Divis	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or within 24 hours atter Within 24 hours atter To the Funeral Dire completely filled in b	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occurred at the tin a and/or investigation, in my o	me, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due t	stated. to the cause(s)
•	To the within 2 To the Comple	W	29b. Signature and title of certifier 30. Name and address of person who co	mpleted cause of death (Rem 23	29c. Licenson	e number 70 3694 20 MEM	OPUAL A	d. Date signed (Month, WWW & OSPINAL)	Day, Year) 2008 Col South
			DAVID C BRU	CK, M.D. 1	SHIBN AVEL	RUE, HA	WRE I	E GRAC	E 21078

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** March 7, 2008 10:40A ^M Bernice Mariea Parker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bon Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛣 F 48 218-74-9817 Director Apr 18, 1959 Marvland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 XYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or 7 21201 420 W. Franklin Street #3 USA Funeral "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo <u>^</u> Specify. 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 School Bus Operator Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Clifton Parker, Sr. Cecelia Sydnor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 W. Franklin St. #3 Baltimore, MD 21201 Tieesha Jackson/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Crematory 03/10/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 The Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a.Sepsis /Medical Due to (or as a consequence of): Examiner b. Human Immunodeficiency Virus Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9X Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia, Dementia, Hyperthyroidism 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The 1∐ Yes 2 🖳 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (*Month, Day, Year*) 03/07/2008 29b. Signature and title of certifier 2 elan MD

State Registrar FALLS ROAD, BALTIMORE, MD 21211

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAR 1 0 2008

31. Date filed (Month, Day, Year,

HNIL

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR &Q

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. ISABEUE MACRETICA, 700 W. 40th Sweet, Balkunore, No 21211

29c. License number

01365

29d. Date signed (Month, Day, Year)

March 7,2008

and manner stated

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per th 8877 3-11-08 Per amend item 7 per the 8877 bepartment of Health and Mental Hygiene Reg. No. 2008 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 2008 10:35aM **Physician** Marie Queen Goldie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1555 N. Woodyear Street Baltimore Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Funeral 1 □ M 3√□ F 83 6-5-1924 MD 220-24-9309 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10h County Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 X Yes 2 □ No Baltimore Director N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 Woodyear Street U S Д 1555 N. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☑ No Specify Baltimore, Maryland 21215-0036 **¾** Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Never (Give kind of work done during most of working life. DO NOT use retired) Worked College (1-4or 5+) Elementary/Secondary (0-12) Never Worked 9th grade uith and Mental Hygie 27 is marked other i r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any ligity or other traumatic evonce. Annie Marie Taylor Henry Taylor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Joan Marie Queen Daughter in 1555 N. Woodyear Street Balto, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State 3-7-2008 Lansdown, MD Mt Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specif 22. Name and Address of Facility 21. Signature of Fusiral Service March F/H East Balto, Md 21202 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) timFArct dementia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 Yes 2 No s certificate has b lirector, page 2 s Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home S Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 ☐ No 2 ER/Outpatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death, neral Director: A filled in by the fu investigation 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Commonstruction of the death of the cause o 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2000 (1)m m(1) 35102 MAYCH Marini 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore marylano 5901 North CHArles Street DONM.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State WAR 10 2008 100 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SICK 9:30 A M IZabeth March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ς izabeth Baltimore V5 1119 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 14,1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Months Days Min. Hours 1 □ M 257 F Yrs. 109-44-7394 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of health and Mentel Hyglene.
ant: If Item 27 is marked other than "natural", or iteme 23s or 28s-1 show ury or other treumatic event, Ite Medical Examinar must be notified at ury or other treumatic event, Ite Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No **Funeral Director** Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3320 Benson Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 4-Teacher Elementary Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Rickle Annie Louise Vaeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen Marlatt - Personal Rep 444 Centre Street; Milton, MA 02186 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If its any injury or of specific 1

Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cem. 4 ☐ Donation 5 ☐ Other (Specify) 3-10-2008 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licen 1630 Edmondson Avenue; Catonsville, 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inluminary disease **Physician** hronic COST ruch V-ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner envi woma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use es the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed ears Monavi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ears Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 20 No certificate 1 Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Other: 4 Volume 1 Residence 6 Other (Specify) Hospital: 1 ☐ Yes _2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours eftar death. To the Funerel Director; A investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and other, and due to the hause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year)

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State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

V, mo

MAR 10

Mina

30. Name and address of person who completed of death (Item 23a) (Type, Print)

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2008

Benson A

32 Registrar's Signature

29c. License number

Baltimire

March 07, 2008

08-01844 Harry Phillip Readmond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 07615

iairy	r mintp rved		- For State Certifi	icate of Death	Reg. No.	000 0701
	Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Yea	3. Time of Death 0754 hrs
Vledi ∽>	cal Exami		Harry P. Readmond 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	March 5, 2008 Death 4c. County of	
			162 cheery Dell Road Cherrydell Rd.	Catonsville	Baltimor	e County
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1212-56-8144 1 M 2 F 56	birthday) If Under 1 Year If Under Months Days Hours Yrs.	24Hrs. 8. Date of Birth (MM/DD/YYYY) Min. May 12,1951	9 . Birthplace (State or Foreign Country) Maryland
	япу		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
	* .	ō	Maryland Baltimore Cat	onsville		1 Yes 2 X No
	r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	nat Country?
	3, MID £1 £1 D-UU30 and 2 should be filed within 72 hours after death with the Maryland tealth and Mortal Hygiene. tem 21 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		162 Cherrydell Road 11. Marital Status 12. Was Decedent Ever in U.S.	21228 13. Was Decedent of Hispanic Origin	USA n? (Specify Yes or No- 14. Race	- American Indian, Black,
)	death or iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican,	, , , , , , , ,	e, etc.
	irs after ural", miner	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 11	1 Yes 2 X No specify: 6a. Decedent's Usual Occupation (Give ki	ind of work done 16b. Kind of Bu	White usiness/Industry
	72 hou in "nat cal Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT u	use retired)	=
ć	Z.13-UU30 be filed within 72 h ttal Hygiene. ked other than "r ent, the Medical I.	ошо	12 17. Father's Name (First, Middle, Last)	Hairdresser	S Name (First, Middle, Maiden Surname	etology
5	ZIZID-UUSO wild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be C	Gordon Readmond	Li11:	ian Mae Paquin	
3	should be filed with and Mental Hygiene 7 is marked other th	ဥ	19a. Informant's Name/Relationship (Type, Print) Rose Readmond Wife	19b. Mailing Address (Street and Numb	per or Rural Route Number, City or Tow oad; Catonsville,	
	e, MU I and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery, ematory or other place)		- City or Town, State
	Pages 1 bent of I unt: If		Dunai 2 24 Cremation 3 Removal from State	ro Crematory	3/6/2008 Catons	ville, Maryland
<u>:</u>	Salumore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:		21. Seriabre of Funeral Survey Doors	22. Name and Address of Facility Funeral Home of	Sterling Ashton So Catonsville, Inc.	chwab Witzke
	Physician		23a. Part I. Enter the disease, or complications that caused the death. D	to not enter the mode of dying, such as ca	Avenue: Catonsvill ardiac or respiratory arrest, shock, or he	eart Approximate Interval Between Onset and
)-	/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Acute Bronche	opneumonia		Death
			or condition resulting in death) Due to (or as a consequence of): b.			
		iner	frany, leading to immediate cause Enter Underlying Cause			
	ansit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
), De exect ician an irial - tr	Medical		.II,27 per me g877	3-21-08 vt	
	LIVISION Of VITAL RECORDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth Pregnant at time of deat	2 Fetal death 3 Ectopic	pregnancy 23d. Date of Month	of delivery Day Year
	BOX 68 / e death certifice the attending 1 ed for use as tl	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			1
(s that th gned by detach	by P	Part II. Other significant conditions contributing to death but not res Atherosclerotic Cardiovascul			tribute to the cause of death? Probably 4 Unknown
	rdS, require been sig rould b	Completed		Discussion of the second	24a. Was an 24b.	Were autopsy findings available prior to completion of cause of
	eco he law ate has	omp			performed?	death? 1 ✓ Yes 2 No
	tal K cian: 1 certific ector. p	Be C	25. Was case referred to medical examiner? Hospital: 4 Legations 2 F	26.Place of Death		- Cothon Soons
	Of VI g Physi fter this eral dir	٦.	1 ✓ Yes 2 No	PR/Outpatient 3 DOA DOR 28b. Time of Injury 28c. Injury at Work		Other: Scene
	tending eath. for: Al	ation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2		
i	LIVISION OF VITAL RECORDS, P.O. ital or Attending Physician: The law requires that thus after death. THE DIRECTOR. After this certificate has been signed by filled in by the funeral director. page 2 should be deated filled in by the funeral director, page 2 should be deated.	Certification:	3 Suicide 6 Could not be determined (Specify)	ne, farm, street, factory, office building, et	cc. 28f. Location (Street and Num or Town, State)	ber or Rural Route Number, City
	DIVISION Of VITAL RECORDS, P.O. B To the Hospital or Attending Physician: The law requires that the di within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge and manner stated.	e, death occurred at the time, date and pla d/or investigation, in my opinion, death oc	ace, and due to the cause(s) and mann courred at the time, date and place, and	er as stated. I due to the cause(s)
_	\$ \frac{1}{2} \times \frac{1}{2}	Me	29b. Signature and title of certifier	29c. License number		oned (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 2	O.C.M.E.	March 5,	
				Penn Street, Baltimore, MD 212	201	
	Regis	tate	31. Date filed (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 /aine nake /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba SCO HVENUE 9. Birthplace (State or Foreign Country) Ndalk If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 Tune 30, 1932 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director da 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 Funeral 0 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21966 19a. Informant's Name/Relationship (Type. Print) Douglas C 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location 1 Burial 2 Termation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Qucer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burlai IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Certification: To Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide I 🚾 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: completely

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11614 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Caypbell

State Registrar 31. Date filed (Month, Day, Year) 0.2008 1

32. Registrar's Signature

			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep Per dr., 877,03/10	artment of Health and Me 108dbb rullicate of Death	ental Hygi	ene g. No. 2008 07617
a,	Physicia	an.	1 Decedent's Name (First Middle Last)		2. Date of Death Month	
	/Medic	al	Jacks VI	F	ebruary	17 2008 11:40a M
	Examin	er	4a. Facility Name (If not institution, give street and number) 12 Bloomingdale Avenue	4b. City, Town, or Location of Death Catonsville		Baltimore
- 40	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Birthplace (State or Foreign
H	Director		219-58-4408	J	July 30	1952 MD
	ryland how		10a. State 10b. County 10c. City, Town or L MD Baltimore Catonsv			10d. Inside City Limits
	the Ma 28a-f s otiffed	Director	10e. Street and Number	10f. Zip Code	110	1 □ Yes 2 🕱 No lg. Citizen of What Country?
	h with		12 Bloomingdale Avenue	21228		SA
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If of Health and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1	Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-00	72 hou natura lical E	sted	15 Decedent's Education 16a, Dece	edent's Usual Occupation	g 1	6b. Kind of Business/Industry
121	within 7	Completed		e kind of work done during most of workin DO NOT use retired) truction worker	9	construction
9	filed v I Hygie other i	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	faiden Surname)
ylar	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	To E	William M. Sutton	Martha H		
Ž	nd 2 sh ulth and 27 is m r traum			^{ing Address (Street and Number or Rural} Clark Dr., Sykesvil		
<u>m</u>	Pages 1 and 2 nent of Health ant: If item 27 i ary or other tra			osition (Name of Date of Ematory or other place) w Memorial 2-20-0	1	ykesville, MD
Balt	permit. Pag Department Important: I any Injury o			22. Name and Address of Facility Haig P.O. Box 195 Sykes		ID 21784
	cate be executed /Medical Examiner the private and the private	dical Examiner	shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	e arrythus -1 arthers	sclor sclor	Approximate Interval Between Onset and Death Wyley Years Years
.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S, P	es that igned k be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
Records ,	requir	eted	Tabetes, Pypercuses	24 ,	1 □ Ye	
ž	he law e has l age 2 s	Completed	DECEMBAL VAR		24a. Was an autopsy perform	y prior to completion of cause of death?
		Be Co	25. Was case referred to medical	26. Place of Death		No 1 Yes 2 No
<u>~</u>	Physic this ce al direc	To E	examiner? 1 Yes 27 No Hospital: 1 Inpatient 2 ER/Outpatie			nce 6 ☐Other (Specify)
00		tion:	27. Manner of leath 28a. Date of Injury 28b. Time 1 Natural 5 □ Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 2 Work? M 1 Yes 2 No	8d. Describe ho	w injury occurred
Division or	or Attending lafter death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		8f. Location (Str City or Town	reet and Number or Rural Route Number,
5	oltal or A					
	To the Hospital or At within 24 hours after of the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) (Check one) (Check only one) (Check one)			
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number	29	ed. Date figned (Month, Day, Year)
	(-)		Melin terden hus	D06582		2 19/08
	(0)		30. Name and address of person who completed cause of death (Item 23a) (Type	PANNAMOLS Nr	nVell	cold Cut 1/1 21042
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 2008	&	un al	

DHMH 17 Rev 1/2001

Box 68760, P.O. Division of Vital Records, within 24 hours after uses...

To the Funeral Director: Aft

> State Registrar

29b. Signature and title of certific

30. Name and address of person

IGAIH!

JOHNS HOPKINS HOSPITAL

D0056293

SSO N. GROADWAY SWITE 308

and manner stated.

MI

145-0

leted cause of death (Item 23a) (Type, Print)

Registrar's Signature

			pe or Print in Blac			-		
	ľ	For State Registrar	tate of Maryland / I		nt of Health and N Te of Death		ne 2008	07619
Physici		1. Decedent's Name (First, Middle Last)	th			2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (* not institution, give street	et and number)	4b. City	Town, or Location of Death		5 2008 4c. County of Dea	
	M	Sina: Hospitl of 5. Social Security Number 6. Sex	Baltimore 7. Age (In yrs. last bi	irthday) If Unde	Baltimone 11 Year If Under 24 Hrs.	8. Date of Birth	I o Bi	rthplace (State or Foreign
Funeral Director	V I		2 X F 85	Yrs. Months		8. Date of Birth (Month, Day, Y	1922	Ounto)/A
hours after death with the Maryland lural", or Items 23a or 28a-f show al Examiner must be notified at	ctor	10a. State 10b. County	Bal.	in or Location				10d. Inside City Limits 1 Noves 2 □ No
3a or 28	I Director	10e. Street and Number 809 A. Brooks A	1		21217	10g	Citizen of What C	ountry?
r death	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - Am Black, Wh	
urs afte al', or It Examin	þ		1	1 □ Yes			Specify:	3 lack
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In mortant: I flem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed			a. Decedent's Usu (Give kind of wi life. DO NOT u	al Occupation ork done during most of work or retired)	king 16	b. Kind of Busines	C G F
d be filed wental Hygie	Be	17. Fitner's Name (First, Middle, Last)	14.c	LI	18. Mother's Nam	ne (First Middle, Ma	iden Surname)	<u>are</u>
2 should and Mer is marke aumatic	2	19a. Informant's Name/Relationship (Type.	Print) 191	b. Mailing Addres	s (Street and Number or Ru			\
1 and Health tem 27		Edwin Smr Th (20b. Place of	of Disposition (Na	me of		onsville, lc. Location - City o	mb 21228 r Town, State
Pages nent of int: If its		1 Burial 2 □Cremation 3 □Rem 4 □Donation 5 □ Other (Specify)	oval from State / T	ery, crematory or M° 80 N	1 1 1	3.08	Dwings	Mills, and
permit. Departr Importa any inju		21. Sign dur of Funeral Service Licensee	Maria	22. Vine a	nd Address & Facility	sene Fyr	real to	The state of the s
		23a. Part1. Enter the disease, or complicate shock, or hear failure. List only one of	ons that caused the death. Do		Bathmore I de of dying, such as cardiac			Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as consequence	al Infa	rction			Onset and Death
Examiner		Sequentially list conditions, b. –	Coronac	01	Disease			
ted nsit	xaminer	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequency)					
executed an and rial-transit	Ш	that initiated events resulting in death) Last	Due to (or as a consequence	of):				
rtificate be ex ng physician	dical	d						
eath ce attendii for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal deatl 4 □ Pregnant at time of death 9 □ Unknown	h 3 ⊟Ectopic p 5 ⊟ Other (s			23d. Date of d Month	elivery Day Year
w requires that the di been signed by the should be detached	by Phy	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying	cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
require sen sig nould b	ted b					1 ☐ Yes	2 No 3 1	Probably 4 (10nknown
	Completed					24a. Was an autopsy performe	prior to ed? death?	autopsy findings available completion of cause of
rsiclan: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	oital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 □ D	Othor:	th (Check only one) ome 5 ☐ Residen	ce 6 DOther /Sr	poiful
ng Phy fter this	\vdash		28a. Date of Injury 28b.		28c. Injury at Work?	28d. Describe how		euny/
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident investigation	28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factor	1 ☐ Yes 2 ☐ No y, office	28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I		29a. Certifier 1 Certifying Physici.	an: To the best of my knowledg	ge, death occurred	at the time, date and place			as stated.
the Ho nin 24 h the Fu npletely	ledical	one)	On the basis of examination a and manner stated.					
viti Cor	Σ	29b. Signature and title of certifier	7	28	c. License number		I. Date signed (Mo	
5		30. Name and address of person who comp	leted cause of death (Item 23a)	(Type, Print)			March 6,	
<i>J</i>		Chad Hansen, M. 31. Date filed (Month, Day, Year)	2401 W &	elofdete	Baltimore	, MA 21.	215	
Sta Registr	_	MAR 1 0 2008		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03-03-2008 **Physician** 1106 A M Michele Eline Stec /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Air Upper Chesapeake Medical Center Bel Ai
If Under 1 Year Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10-19-1957 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 50 Maryland Director 215-50-9542 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 21 No Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 420 Cedarsprings Rd 21015 U.S.A. Funeral 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Wire Operator Stock Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Eline Mary Catherine O'Rourke Pages 1 and 2 should sent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Thomas Stec (Husband) 420 Cedarsprings Rd Bel Air, MD 21015 ģ Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition timor 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 03-07-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) athers scientic commany vancular disease **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ending physician and use as the burial-transit Due to (or as a consequence of): 68760 death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes Record 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ≥ ER/Outpatient 3 DOA Ö 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 D45904

State Registrar

20

9524 Belair Ra Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

KRUSTINE C. SALL

31. Date filed (Month, Day, Year) MAR 0 7

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F <i>rtificate of</i>		Mental Hy	gien Reg. N	/ 11	08	07622
	Physici	an	Decedent's Name (First, Middle, Las	t)				2. Date of De Month	eath)av	Year	3. Time of Death
N. S.	/Medic	al	Irene Sina Sapack 4a. Facility Name (If not institution, give	street and number)		4h City Town o	or Location of Death			2008 c. County	of Death	1:45 A. [™]
No.	Examin	ier	6517 Hilltop Avenue	Street and numbery		Baltim	ore	'		ľ	V/A	
	Funeral Director		220-20-2000		(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da August	25,	^{r)} 1929	9. Birthp Cour Mary	place (State or Foreign Mry) Land
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					1	10d. Inside City Limits
	e Man 3a-f sh tified	ctor	Maryland N/A		Baltimore	9						1 ☐Yes 2 🔀 No
	ath with th 23a or 24 Lust be no	Funeral Director	6517 Hilltop Avenue			10f. Zip Code 21206			US			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	Blac	e-Americk, White,	
15-0	n 72 h "natu	letec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	ı (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor.	king	16b.	Kind of Bu	ısiness/In	dustry
212	d withing jiene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+	Cash		υ)		Pan	itry Pr	ride	
ng	be filectal Hyg	8	17. Father's Name (First, Middle, Last)				18. Mother's Nam	, ,	, Maide	en Surnan	ne)	
z	hould d Men marke martic	卢	Norman Tyler 19a. Informant's Name/Relationship (7)	ivoa Printì	10h Maili	na Addraes (Stroot	Audrey and Number or Ru		or Cit	, or Town	Stata Zir	a Cada)
Ma	s 1 and 2 s of Health an Item 27 Is r other traus		Charles R. Sapack/ Hus				nue Baltim					Codey
Baltimore, Maryland 21215-0036	Pages 1 and the part: If Item ant: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		1	matory or other pla	_{ce)} Gardens 3-	Date 11-08		Location -	-	own, State and
Balt	permit. Departr Imports any Inji		21. Signature of Funeral Service Licen	Velton	- [d Road Bal			ınd 21	214	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to one cause on each line	he death. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory a	arrest,			Approximate Interval Between Onset and Death
H	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Anorexio	consequence of):							months
	Examiner			1	consequence or).							months
-	po to	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U.	consequence of):						is.	
V _	xecute and	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):							
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_	ertifica ling ph e as th	Med	IF FEMALE:	001/	,							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у				te of deliv	ery Day Year
S,	ss that gned b	by Pl	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco	o use cont	ribute to t	he cause of death?
ord	require sen sig rould b	ted t	(000					1 🗆	Yes	2 No	3 Prol	bably 4 □Unknown
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tal	ificate or, pag		25. Was case referred to medical				26. Place of Dea	1□ Yes	2			2□ No
	nysicia lis cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3 DOA Oth		ome 5 Res		6 □Oth	er (Speci	fy)
o uc	ding Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Woi		28d. Describe				
Division or	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, farm, st (Specify)		163 2 110	28f. Location (er or Run	al Route Number,
	pital o	O	200 Cartifice 1 autifulus Phy	0		th page urrad at the ti	ma data and place					stated
	e Hos 24 ho e Fund detely 1	edical	29a. Certifier 1 ✓ ertifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of iner: On the basis of and manner stat	examination and/or ir	nvestigation, in my	me, date and place opinion, death occu	r, and due to the urred at the time	, date a	and place,	and due t	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. E	Date signe	d (Month,	Day, Year)
				mo		D 31	295			3/1	3/01	
	0		30. Name and address of person who de wends Moese	COTHY H C	Land's St	Pinta 42	62 7 cms	ion V	nd	21	207	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	de la					,	
	Registr	ar	MAR 1 0 2008	Jacob Contraction of the Contrac	- 17							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Anne Louise Streit 2008 3:40 March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🕱 F 86 Maryland Jan. 30,1922 220-24-4951 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2KINo Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 125 D Versailles Circle 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Franklin Miller Alberta Susan Pomeroy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Streit Daughter 125 D Versailles Circle; Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Hebron Cemetery 3-8-2008 Winchester, Virginia 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD Me 23a. Part1. Enter the sease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Moke Due to (or as a consequence of): > disease Vascular Sequentially list conditions, if any, leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 K No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Venous twentoentak disate 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Stother (Specify) Way û 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work?

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

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"natural", or Item edical Examiner o

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of Health and Mering.
If Item 27 Is marked other th

= ö Department of Important: If any injury or

Items

Director

Funeral

Completed by

Be

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with the Maryland

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

burial sician the

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Certification: To After this the

Director:

Division or Vital Records, P.O. Box 68760.

Physician/Medical Be Completed by

filled in by within 24 hours a

To the Funeral C

completely filled

10

State Registrar

Medical

31. Date filed (Month, Day, Year)

27. Manner of Death

Naturai

2 Accident

4 ☐ Homicide

29a. Certifier

29b. Signature

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chresles 32 Registrar's Signature

and manner stated

Date of Injury (Month, Day Year)

670/ N. Chunes ST TONSUN MO ZING

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3.6.08 11 PM SEITZ, HARRY

			Please	State of Manuford				•	-	
			For State	State of Maryland		ent of Health ate of Death			2008	07624
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Certino	ale UI Deali		Reg.	No. O O O	3. Time of Death
	Physici		Heart	S. +2 To				Month	Day Year	1100 DM
8-	/Medio		4a. Facility Name (If not institution, give	street and number)	4b. (City, Town, or Location	n of Death	acen	6 , 2008 4c. County of Deat	1
	- Examin	ic.	Bilchoist 1th	Shice		Towson			Ralha	IORC
	Funeral		5. Social Security Number 6. Se		Mon	nder 1 Year If Unde	er 24 Hrs. 8.	Date of Birth	n Rid	nplace (State or Foreign
	Director		213-34-5576	V M 2□F 68	Yrs.	Days Hours	A	Month, Day, Y	939	ND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location					10d. Inside City Limits
	/any।ह i sho ed at	5	N D I		. /					1 □Yes 2 🗗 No
	the 28a-	rect	10e. Street and Number		1/ more	. Zip Code		10g	. Citizen of What Co	untry?
	3a or	Ö	4132 Cliff	vale Road		21236			U.S. A	
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	ecedent of Hispanic C specify Cuban, Mexic	Origin? (Specify	/ Yes or No-	14. Race - Ame Black, White	
9	after or ite		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		s 2 No Specif		an, etc.)	Specify: / /	, etc.
5-0036	"natural"; "natural";	Completed by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			,	- 140	\mathcal{U}	RIFE
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	should be filed within 72 ho nd Mental Hygiene. marked other than "natu matic event, the Medical	Be C	17. Father's Name (First, Middle, Last)	_	77,000			irst, Middle, Ma	iden Surname)	y
lan	Duid be Mental arked o	To B	HARRI F. Seit	z. Sr.		E	thel	DOWNE		
Maryland	ar is		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailing Add	ress (Street and Num	ber or Rural R	oute Number, C	ity or Town, State, 2	ip Code)
	s 1 and 3 lifem 27 other tra		Michael Seitz	- JON .	1401 Sa	Ndy Ridge	Rd.	Mann	ing, SC	29102
ore	of of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	005	ce of Disposition in metery, crematory	(Namle of or other place)	Date	20	c. Location - City or	Town, State
Ë			4 ☐ Donation 5 ☐ Other (Specify	Day	yview Cre	matary:	3-10-	08	Baltimo	re, MD
Baltimore,	permit. Pag Department Important: any injury conce.		21. Signature of Funeral Service Licen	900	22. Nam	e and Address of Fac	ellity Bra		ASKLON 1	
			23a Part1 Enter the disease or comm	plications that caused the death	Do not enter the	mode of dying such a	34 Williams	Seniratory arrest	Sring R	d. 21222 Approximate
	Discourse in the second		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.			30 0010100 01 11	opriatory arrow		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. MCONIII C Due to (or as a conseque		rhosis				years
F	Examiner									
ø		Je.	Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):				7.5	
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×	certific iding p	Physician/Medi	IF FEMALE:	23c. If yes, outcome pf pregnance	су				23d. Date of del	ven
Вох	attending	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		ic pregnancy r (specify)			Month	Day Year
0	at the de by the tached	hysi	9 Unknown	9□Unknown						
σ, Θ	requires that the death certificate een signed by the attending phys rould be detached for use as the	by P	Part II. Other significant conditions of	ontributing to death but not resulti	ing in the underlyi	ng cause given in Par	t I.	23e. Did tobac	co use contribute to	the cause of death?
or Vital Records,	w require been sig should b	edi						1 ☐ Yes	2 No 3 Pr	obably 4 □Unknown
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or	hys this al dii	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 Ef	R/Outpatient 3				e 6 Other (Spe	city) Mosple
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Ο̈́	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		,,		City or Town, S		,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			ysician: To the best of my knowl						
	he H(in 24 he Fu pietel	Medical	(Check only one) (2 Medical Exam	niner: On the basis of examination and manner stated.	on and/or investiga	ation, in my opinion, d	eath occurred	at the time, date	e and place, and due	to the cause(s)
	To the vithin 7 To the comple	Ž	29b. Signature and title of certifier	100		29c. License number		1	Date signed (Mont	
	1		A A COLOR			1) 58'50	3	//	49-44 7	2008
-	h		30. Name and address of person who c	completed cause of death (Item 2	23a) (Type, Print)	D 5830	ST TO	NSIN .	MD 2121	74
		10	13170011	32. Registrar's Signatu		0.01-001	, , , , , ,			•
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07625 Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 12.22 pm A. ucker 2008 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Good Samaritan 5. Social Security Number 6. Sex BALTIMORE
If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month. Day 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 M Months Hours 218-68-5535 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a1239 1202 Winston Ave Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 ☐ No Specify Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist and Mental Hygi Injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be ealth and Mental ပ Jeorge Nolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other trau Baltimore, MD 21239
Date 20c. Location - City or Town, State Josephine Johnson 20a. Method of Disposition 1209 Winston Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, ML 4 □ Donation 5 □ Other (Specify) Mt 2100 /11/2008) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Greene Fineral services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MIS 21212 Immediate Cause (Final disease or condition resulting in death) Grain mying **Physician** Annic /Medical Due to (or as a consequence of): Examiner sloc whi c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOO 03/04/2008 GOOD SAHARITAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANIA MISSEH

State Registrar

2

BALTIMORE

5601 LOGHRAVEN BLVN P 2008 Registrar's Signature

State Registrar 29b. Signature and title of certifier

tyleen

Year)

2008

10

31. Date filed (Month, Day,

29c. License number

Union Memorial Mospital

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ampa

08-01813 Joseph Henry Trail, 2nd

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 07627

		For State		Ce	ertificate	of I	Death					eg. No.			
Physiciar ical Examin	1	. Decedent's Name (First, Midd	Joseph Henry Trail, II 2. Date of Death Month Day March 4, 2008								Year		3. Time of Death 0335 hrs		
		a. Facility Name (if not institution 7126 East Furnace Bi		umber)		4t	b. City, Tov Glen Bu		ocation of	Death		- 1	c. County of Anne Aru		
Funeral	5	. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under	1 Year Days	If Under Hours	24Hrs. Min.				Foreig	
Director	- 1	212-70-3200	1 X M 2 F	52		Yrs.			<u> </u>		02-25	5-19	56	Col	untry) MD
<u>.</u>	_	Usual Residence of Decedent Oa. State 10b. County		10c. Ci	ty, Town or Lo	catio	on								10d. Inside City Limits
d now any			Arundel					Gle	n Bu	rnie	<u> </u>				1 Yes 2XX No
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	0e. Street and Number	712 001002		·		10f. Zip C			-		10g. Ci	tizen of Wha	at Coul	ntry?
he Ma 1 or 2		303 Rainwater	Way, Uni	it 104				2	21060			Ur	nited_		
with t		1. Marital Status	12. Was D	ecedent Ever in Forces?	U.S. 13	Was	s Decedent	of Hisp Cuban.	anic Origi Mexican.	n? (Spe Puerto F	cify Yes or N Rican, etc.)	io-	14. Race White		ican Indian, Black,
21215-0036 uld be filed within 72 hours after death wi Mental Bygiene. marked other than "natural", or items c event, the Medical Examiner must be	Funeral	1 Never Married 2 N	1 Yes	2 X No				_					Specify:		White
s after	<u>اھ</u>	3 Widowed 4 X Di 15. Decedent's Education (Spe	vorced If Yes, Give Y				Yes 2 7	_		ind of wo	ork done	16b	. Kind of Bus	siness/	
"natu Exan	ᅙ	Elementary/Secondary (0-12)		(1-4 or 5+)	duri	ng mo	ost of worki	ng life.	DO NOT I	se retire	ed)				
)36 hin 72 e. than	Completed	12	,		Ma	int	tenan		Work						ng Co.
5-00 ed wit tygien other he M	ᆰ	17. Father's Name (First, Middle	e, Last)					1			(First, Middle)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Joseph Henry			1401 14	-111		(0)	Es	ther	Rings	staf	City or Tow	n State	e, Zip Coda) 21060
Should and Me	\vdash	19a. Informant's Name/Relation Esther J. Trai		2.75											nie, MD
au 2 da Z		ESTREE J. ITal	LI - MOCIN		b. Place of D	spos	ition (Name			<u>y,</u> c	Date	200	c. Location -	City o	r Town, State
Ore ges 1 a t of H		1 Burial 2 K Crematic			crematory			V-1 7	ĺ	Ma 7	2008		Catons	vil	le, MD
		4 Donation 5 Other S 21. Signature of Funeral Service	- 17		Metro				of Facility						eral Home at
Balt permit. Departi Importi	T.	Harle M.	Broka	0053	I	MMI	P, In	c.,	/250	Wasr	i. BIV	a.,	EIKri	age	e, MD 210/2
Physician	1	23a. Part I. Enter the disease, of failure. List only one caus	or complications that	t caused the de	ath. Do not e	nter ti	he mode of	dying,	such as c	ardiac or	respiratory a	arrest, s	shock, or he	art	Approximate Interval Between Onset and
'Medical kaminer	1	Immediate Cause (Final diseas		e Intoxio	ation										Death
. Adminier		or condition resulting in death)	Due to (or a	s a consequenc	ce of):										
	F	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequent	ce of):										
	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	Due to /or s	s a consequenc	e of):							_		-	
ted Insit	Exa	events resulting in death) Last	d.	s a consequent	Se 01).										
8760, ificate be executed g physician and is the burial - transit	/Medical	X UNPENDED	XX AMENDE	D 23a, 2	27, 28a-	fр	er ME	g877	3/18/	'08 ar	nh				
1760, ficate be g physic s the bur	/Mec	IF FEMALE: 23b. Was decedent pregnant in		es, outcome of p		7 -		2	Ectopi	c pregns	ency		23d. Date o Month	f delive	ery Day Year
68 certifi		past 12 months?	1	re birth egnant at time o	of death 5		etal death other (Spec			c pregne	inoy	1			,
Box 68 e death certif the attending ed for use as	Physicial			known							-	\perp			to the arrive of death?
O. In the rd by the etache		Part II. Other significant cond	ditions contributir	g to death but r	not resulting is	the	underlying	cause	given in P	art I.					to the cause of death?
ires th	od by										24a. W				autopsy findings available
ords w requ	plet										au	utopsy erforme			o completion of cause of
Reco	Completed										1 🗸 Y	es 2	No	1 🗸	Yes 2 No
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be	25. Was case referred to medi examiner?	ical Hospital:		FROM	-41			of Death Other	-	only one)	Re	sidence 6	✓ Ot	ner: Scene
F Vit Physic ar this	၉	1 ✓ Yes 2 No 27. Manner of Death	1	Inpatient 2	ER/Outp			OA 28c. Inju	ury at Wor				injury occu		
ding Afte	on:	1 National		ate of Injury onth, Day,Year)	foun		′ ′	-	Yes 2		unk				
Sissipar Atten	icati	2 Accident In	vestigation	d 3/4/08 Place of Injury -				, office	building, e	etc.	28f. Locatio	on (Stre	et and Num	ber or	Rural Route Number, Cit
Divi	Certification:		ould not be	ify) found							Glen B			. Ft	irnace Branch R
Hospi 24 hou Funer tely fil		29a. Certifier (Check only 1 Certifying	Physician: To the Examiner:On the ba	best of my kno	wledge, death	occu	urred at the	time, c	ate and p	lace, and	d due to the	cause(s	s) and mann	er as s I due to	tated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of cer	and mann	er stated.					se numbe						Month, Day, Year)
	2	29b. Signature and title of car	-Pao	0.e.m					м.Е.			ŀ	March 4,	2008	
04		30. Name and address of pers		cause of death	(Item 23a)	ner	111 P	enn S	Street P	altimo	re, MD 21	1201			
U	tate	Patricia Aronica-Po 31. Date filed (Month, Day, Ye		2. Registrar's Si		.01		J. II. C							
S Regis		MAR 1	0 2008	Elegene o	JK.	do	ask s								
DHMH 17 Rev 1/2	2001		OCIME		OR	GIN	AL.								

			for State Registrar	State of Marylar		rtificate of			Reg. No. (8002	07628
io.	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	al	Martha R.			45 60 7	-land Dark	March	5,	2008	8:20 AM
,	Examin	er	4a. Facility Name (If not institution, given Union Memorial Hos				r Location of Death cimore		4c. C	ounty of Death N/	′ A
	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	h Vens	9. Birthp	lace (State or Foreign
	Director		215–28–6456	□ M xex F	78 Yrs.	Months Days	Hours Min.	1-5-19	30 year)	Mary	rland
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Le	ocation				1	0d. Inside City Limits
	Aaryla f shored at	ō	Maryland N/		.,,		Balt	timore			XX Yes 2 No
	the N 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Coun	itry?
:	h with 23a ol st be	al Di	3652 Beech Ave	enue		2	1211			USA	
	ems a	ıner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	. 14	I. Race - Americ Black, White,	
20	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. And other than "natural", or items 23a or 28a-f show event, the M-dical Examiner must be notified at	by Funeral Director	1 ☐ Never Married ★★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		s	Specify: whi	.te
3	thour stural		15. Decedent's Ed	ducation	16a. Dece	edent's Usual Occup	ation		16b. Kind	of Business/Inc	dustry
0	hin 72 e. an "ng M dic	Completed	(Specify only highest gra	completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	during most of wor d)	king			
7	ed wit ygjen er th t, the	Con	12		Но	memaker				Own hom	ne
<u>a</u>	be file	Be	17. Father's Name (First, Middle, Last))			18. Mother's Nam			urname)	
<u> </u>	should and Men s marke umatic	٦	LeRoy Baker 19a. Informant's Name/Relationship (Type Print	10h Maili	ing Address (Street		ry Hedri		Town State Zin	(Code)
_	nd 2 s Ith an 27 is r traur		Edward C. Turner	Husband	1	Beech Av		Baltimor			21211
ע	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b.	Place of Disp	osition (Name of	ce)	Date		ation - City or To	
2	Pages nent of int: If its iry or o		1 XX urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Du	laney	Valley Me ardens	morial 3,	/8/08	Timo	onium, M	Maryland
Dallinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparatment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at once.		21. Signatur of Funeral Service/Lio	see		22. Name and Addre	ess of Facility		eral	Home I	nc
•	6 5 5 5 5		(flangt	asporter		3631 F	-Henss-Se alls Road	<u>Balti</u>	more,	Maryla	
			23a Part . Enter the/disease, or com shock, or heart/fallure. List only								Approximate Interval Between Onset and Death
'n.	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. End Stage Due to (or as a conse	Sever	e Chroni	cobstm	ich ve l	ung	Disease	40 years
•	Examiner			Due to (or as a conse	quence or):						
7-		ner	Sequentially list conditions,	b. Due to (ur as a conse	quehle Ul):						
/	ocuted nd transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
Š	oe exectan a	Ä	resulting in death) Last	Due to (or as a conse	quence of):						
00/00	rificate be executed ig physician and as the burial-transit	ledical		_d							
X	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr					23	3d. Date of delive	ery
. DOX	w requires that the death cer been signed by the attendin should be detached for use	Physician/N	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnand □ Other (specify) _	У			Month	Day Year
5	at the by the tache	hys	9 ☐ Unknown	9□Unknown							
'n	es the	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause gi	ven in Part I.				he cause of death?
Records	een s	ted							res 2	No 3 ☐ Prob	
ည	e law has b	Completed						24a. Was		24b. Were auto prior to co death?	opsy findings available impletion of cause of
_	slcian: The law s certificate has b lirector, page 2 s		25 11					1□ Yes	2 No	1 ☐ Yes	2□No
VII.al	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	TER/Outpatie	ent 3 DOA Ot	nor:	ath <i>Check onl</i> d dome 5☐ Resi		□Other /Specie	f ₄)
0	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju		28d. Describe			
000	arth. or: After ne funera	atio	1 □ Matural 5 □ Pending 2 □ Accident investigation	n	lingury		Yes 2 □ No				
UNISION	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		nome, farm, s	treet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
2	pital o		29a. Certifier 12 Certifying PI	nysician: To the best of my kn	owlodgo doo	ath accurred at the t	imo, dato and place	and due to the	nauen(e)	and manner as	stated
	e Hos 24 hc e Fun etely	Medical		miner: On the basis of examinand manner stated.							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. Licen	se number			signed (Month,	
			Golom K.	damba. N	1.D.	AT 2	43894	16	Marc	ch 51.	2008
	:0		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Drint)					
	1		Atleen K. L	amba, M. 32. Registrar's Sigr	V. Un	ion Memo	nal Hosp	oital,	MD		
d	Sta Registi		31. Date filed (Month, Day, Year)	2008 Line s Sign	Talul C	Most!	•				
			MINIT U	TOO THE SERVICE OF TH	00						

Type or Print						
State of Mary	dand / I	Denartment	of He	ealth and N	/lental	Hygiene
State of Mai	ylalla / I	Department		Janeir and r		,

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Charles A. Talbo		I- For State	State of	f Maryla		oartment o e <i>rtificate o</i>			Menta	al Hygiene	Reg. No	20	0 (8 0762
Physicia	an/	Registrar 1. Decedent's Name (First, M				<u> </u>	_			2. Date of Month	Death Day	Year		3. Time of Death 1637 hrs
Medical Exami	ner	Charles Alb					4b. City, To	um or l	acation of	March	4, 2008	4c. County of	Death	103/11/5
V. 1-		4a. Facility Name (if not instit 3415 Chestnut Ave	ition, give s	treet and nur	nber)		Baltim		ocation of	Deatti		N/A	Dodan	
Funeral		Social Security Number	6. Sex	T	7. Age (In yrs	s. last birthday)	If Unde	r 1 Year	If Under	24Hrs. 8. Date of	f Birth (M	WDD/YYYY)		place (State or Foreig
Director		213-54-1244	10000	1 2 F	58	Yn	Months s.	Days	Hours	Min. Aug.	20,	1949		ntry) cyland
		Usual Residence of Deceden												
v any		10a. State 10b. Coul	•		10c. Ci	ty, Town or Loca							- 1	10d. Inside City Limits 1 X Yes 2 No
land f show	Į.	Maryland N/				Baltimo		Orde			1100.0	Citizen of Wha		177
Mary r 28a- ed at	Director	10e. Street and Number 3415 Chestn	1+ Axzc	muo			10f. Zip	2121	11		109.0	US		uy:
r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status		12. Was Dec	adent Ever in	IIS 13 W	as Decede			in? (Specify Yes o	or No-			can Indian, Black,
ath w items	Funeral	1 Never Married 2 🔀	Married	Armed Fo	rces?	lf `	Yes, specif	y Cuban,	Mexican,	Puerto Rican, etc.)	White,		
fter de		3 Widowed 4	Divorced If	1XX Yes Yes, Give Year or Dates:		1	Yes 2	X No	specify:			Specify:	Whit	te
ours a	d by	15. Decedent's Education (Specify only	highest grad	e completed					ind of work done use retired)	161	. Kind of Bus	iness/Ir	ndustry
6 n 72 h	Completed	Elementary/Secondary (0-	12)	College (1	-4 or 5+)					,		a	.	
within siene.	mo	11 17. Father's Name (First, Mic	dle Last)			Carpe	enter	1	8.Mother's	s Name (First, Mid		Constr	uct.	LOII
filed at Hyg	Be C	Charles All	pert 1	Calbot	t, Sr.					Mary Mau			en	
212 ould be Ment mark	To E	19a. Informant's Name/Relat	onship (Typ	e, Print)		19b. Maili	ng Address	(Street	and Num	ber or Rural Route	Number	, City or Towr	n, State	, Zip Code)
MD 12 sho th and 127 is	Ė	Margaret A.	[albo	tt W	ife						Balt	imore,	Ma	ryland 212
re, s 1 and f Heal f item er tra		20a. Method of Disposition 1 Burial 2 X Cremi	ation 3	Removal fro		b. Place of Dispo crematory or o			netery,	Date	- 1	c. Location -		
Pages nent o		4 Donation 5 Othe	r Specify:		M	letro Cre		-		3/12/200				e, Marylan
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heafth is and Mental Hygiewith finaportanes. If item 71 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signation of Funeral Ser	rice License	e)	22 Bi	Name and	Address -Hen:	of Facility	itz Fune	ral	Home,	Inç	. 21211
		23a. Part I. Enter the disease	g. X	Hus	J. aused the de	30	031 F	STTE	Koac	ı, Baltın	юrе,	Maryi	.and	Approximate Interv
Physician /Medical		failure. List only one ca	use on eacl	h line.				,g.						Between Onset an Death
⁻ xaminer		Immediate Cause (Final dise or condition resulting in dea	_	ue to (or as a		iovascular Di	sease				_			
		Sequentially list conditions,	b	(** ***										
	iner	if any, leading to immediate cause. Enter Underlying Ca	ušā	ue to (or as a	consequenc	e of):								2
1 -	Examine	(Disease or injury that initiat events resulting in death) L	ed C. =	ue to (or as a	consequenc	ce of):								
60, e be executed ysician and burial - transit	a E		d	····										
O, be exercision	edical	UNPENDED		AMENDED										<u> </u>
Box 68760 he death certificate I the attending physhed for use as the bh	ian/Me	IF FEMALE: 23b. Was decedent pregnant	in the	23c. If yes,	outcome of pointh		etal death	3	Ectopi	c pregnancy		23d. Date of Month		y Day Year
Box 6876 e death certificate the attending phy ed for use as the	icia	past 12 months?			nant at time o	11	Other (Spe	cify)			- 9			
Bo re deat the at	Physici	1 Yes 2 No 9	Unknown	9 Unkn					ives in De	230	Did toba	cco use contr	ibute to	the cause of death?
s, P.O. Be uires that the de signed by the d be detached f	by P	Part II. Other significant co				ot resulting in the	underlyin	g cause g	jiven in Pa					bably 4 🗸 Unknow
IS, F quires en sign	ted	Chronic obstructiv	e pullio	nary uisea	156			_			Was an			utopsy findings availal
ord aw rec as be 2 shou) ge									_	autopsy performe		prior to death?	completion of cause o
Division of Vital Records, P.O. in or Attending Physician: The law requires that the rs after death. The intercor: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed							-	(6 "	1	Yes 2	No 1	Y	es 2 No
ital ician: s certif	B B	25. Was case referred to me examiner?		ospital:	Inpatient 2	ER/Outpatie	nt 3 1	26.Place	Other ₄	(Check only one) Nursing Home	5 Re	sidence 6	Othe	er: Scene
Physical this stal dispersion	은	1 Yes 2 No		28a. Date	·	28b. Time of			ry at Worl			v injury occur		
on C nding th. r: Aft	<u>i</u>	1 V Natural 5	Pending	(Mont	n, Day,Year)			_1	Yes 2	No				
r Atter er dea rector	ig	2 Accident 3 Suicide 6	Investigatio Could not b	28e Plan	ce of Injury -	At home, farm, st	reet, factor	y, office b	uilding, e				er or R	ural Route Number, C
Div ital of urs aff	Certification:	3 Suicide 6 Homicide	determined)					orı	own, Stat	e)		
Division of Vital Records, P.O. Box 6876 the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. Frueral Director: After this certificate has been signed by the attending phy phelety filled in by the funeral director, page 2 should be detached for use as the t	alc	29a. Certifier 1 Certifyi	ng Physicia	n: To the be	st of my knov	wledge, death oc	curred at th	e time, d	ate and pl	ace, and due to th	e cause(s	s) and manne	r as sta	ited.
Division of Vital Records, To the Hospital or Attending Physician: The law required the Attending Physician: The law required the Attendent of	Medical			On the basis and manner:	of examination	on and/or investi				ccurred at the time				
->-	Ž	29b. Signature and title of c	ertifier	() in			29		se number	г		9d. Date sign March 5, 2	,	onth, Day, Year)
		Mun D	ane	4/11	4			O.C.	IVI. C.			VIGIOI 0, 2		
JX/	7	30. ame and address of policy Melissa Brassell,		ompleted cau sistant Me			Penn S	treet F	Baltimor	re, MD 21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2 Date of Death Physician /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mill Mayor Nwsing Home imber 6. Sex 7. Age (In yrs-dast birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ ★ 218-22-7702 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Kesuille 10g. Citizen of What Country? 10e. Street and Number 21208 by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number; Pilesville Niece Och Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City 1 Burial 2 ☐ Cremation 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disemp **Physician** Chronic PULMMany OBSTRUCTIVE disease or condition resulting in death) 10 yeurs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed Pulmmany 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe Meumatord Arthritis 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To in the incr.
within 24 hours after deam.

To the Funeral Director: After this in the Funeral dilection and the funeral dilection by the funeral dilection. 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1030377 30. Name and address of purion who completed cause of death (Item 23a) (Type, Print) HEIGHTS Treeto M. COOPER 6503 PARK WW

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Physician 30PM B /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 152CI SPITAL BALTIMORE 0 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 □ F Director 83 1924 220-18-6088 12. Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County ia or 28a-f show t be notified at show Maryland 1 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with r items 23a c 21224 U.S.A. 100 N. Glover Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerio Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene Hardware Store 12 Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic even Alma Harrier John Weider မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i George Weider/Brother 9 Oueen Anne Road, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □Cremation 3 □Removal from State March 11 Parkwood Cemetery 4 Donation 5 Dother (Specify) Baltimore, MD 2008 22. Name and Address of Facility Rendon-Bailey Funeral Home, P.A. Signature of Funeral Service Licensee 2818 E. Baltimore St. Baltimore, MD 21224 /M00969 | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

300

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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8-01901 lary Catherine Win		lease Type or Print State of Mar	t in Black Inde yland / Departn			0 0769	
	1- For State Registrar		Certifi	cate of Death	Reg. No	200	8 0763
Physician/		nme (First, Middle,Last)			2. Date of Death	Year	3. Time of Death
Medical Examiner	Mary	Catherine	Winters		Month Day March 7, 2008	3	1108 hrs
4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of De	eath	4c. County of Death	1

		I- For State Registrar	Certificate of Death Reg. No.								JUI	5 0/53				
Physicia		1. Decedent's Name (Fire	dent's Name (First, Middle,Last) 2. Date of Death								Year		3. Time of Death			
edical Examir	ner	Mary Catherine Winters March 7, 2008										1108 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location							ocation of	Death	eath 4c. County of Death Howard					
		8145 Cypress C	3145 Cypress Cedar Lane , Apt D Ellicott City													
Funeral		5. Social Security Number	er 6	Sex	7. Age (I	n yrs. last b	oirthday)	If Unde	s Days	If Under:	24Hrs. 8 Min.	B. Date of Bi	rth (MM/DE)/YYYY)	Foreign	
Director		213-54-0548	3 1	M 2XXF		58	Yrs.		Juys	110013		06-2	0-194	.9	Cour	ntry) MD
		Usual Residence of Dec														10d. Inside City Limits
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Maryl 28a- d at c	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cour														
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ms 2.	Funeral	11. Marital Status		12. Was D	ecedent Ev Forces?	er in U.S.			ent of Hispa fy Cuban, I			ify Yes or No	0- 14	4. Race White		an Indian, Black,
death or ite	ä	1 Never Married		1 Yes	23(3	\$ No			_			,	i			TuTle of the co
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with spiene bler t	E	17. Father's Name (First	Middle		•		Auche)I / aI		8.Mother's	Name (F	irst, Middle,	Maiden Si			<u> </u>
Hyped of	BeC	Cecil Lav			Sr.						,	Mari				
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than c event, the Medica		19a. Informant's Name/F					19b. Mailing	Address	S (Street			ral Route Nu			n, State,	Zip Code)
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	-1	Michael B.	. Decl	cer - Br	other	2	2220	Sier	na Way	y, Wo	odst	ock,	Maryl	.and	211	63
and and Health	- 1	20a. Method of Dispositi					e of Dispos			etery,		Date	20c. Lo	cation -	City or 7	own, State
more Pages 1 nent of H ant: If it		1 XX Burial 2 C			from State	1	natory or oth owride			ark	Mar	cn 2008	Fir	rid	TO.	Maryland
Baltimore, permit. Pages I are Department of Hee Important: If ite injury or other tr	- 1	4 Donation 5		_	0052	Meado										al Home at
Baltimo permit. Page Department o Important:	ļ	Made	9	5.40	0053		MME	o. Ir	nc	7250	Wash	i. Blv	d., E	Elkr	idge	, MD 21075
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/Medical		failure. List only or Immediate Cause (Final		n each line. a. Chroni C C	bstructiv	ve pulmo	narv díse	ease								Death
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760, ficate be g physic t the bur	8	IF FEMALE: 23b. Was decedent preq	nont in the			of pregnan									delivery	
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Box 68 death certif the attending	Physician	1 Yes 2 V No 9	Unkn		known		5 Of	ther (Spe	ecity)							
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of Vital Records, ing Physician: The law requirenthis certificate has been someral director, page 2 should	Completed											24a. Wa	s an opsy	24b. \	Were au	topsy findings available ompletion of cause of
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Division tall or Attendin safter death.	fica	2 Accident 3 Suicide 6	Invest	gation 28e. P	ace of Inju	ry - At home	e, farm, stre	et, factor	y, office bu	uilding, etc	c. 2			nd Numb	er or Ru	ral Route Number, City
Divipital o	Certification:	3 Suicide 6 4 Homicide	detern		fy)							or Town,	State)			
Hosp 24 hou Fune tely fi		29a. Certifier 1 Cert	tifying Phy	sician: To the l	est of my	knowledge,	death occu	rred at th	e time, dat	te and pla	ice, and d	ue to the ca	use(s) and	manne	r as state	ed.
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	C(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year										e cause(s)					
F × F S	Me	29b. Signature and title	of certifier	Sile iligitity				29	c. License	number			29d. D	ate sign	ed (Moi	nth, Day, Year)
		Josh Hegrup O.C.M.E. March 8, 2008														
1.7		30. Name and address	of person v	vho completed c	ause of de									_		
Q		Tasha Greenbe	erg MD.	Assistant	Medical	Examine	er 111	Penn	Street, I	Baltimor	re, MD	21201				
	tate	31. Date filed (Month, D	ay, Year)	32.	Registrar's	Signature	AP.	acht B								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State amend #16a&b PER FH G877 3/10/08/III
Registrar Registrar Registrar Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Waller Reb 7 03A M James 27 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Maryland University of Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 1 XM 2 ☐ F 214-56-7766 56 3 4 1951 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 10a. State Y☐Yes 2☐No Director MD N/A Baltimore with the 10g. Citizen of What Country? 10e. Street and Number Apt 10 a or U S Α 727 Druid Park Lake Drive 21217 r than "natural", or items 23a the Medical Examiner must b death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☑ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Never Never Worked <u>10th grade</u> and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be James Lee Waller, Sr Thelma Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Vernita M. Cox - Sister 4334 Parkside Drive Drive Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐Removal from State Mt Carmel Cemetery 3-4-2008 Balto, MD 4 Donation 5 Other (Specify) 21. Signature Truneral Privice Licenses 22. Name and Address of Facility March F/H East 21202 1101 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cirrhosis -iver **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) Box 68760. ed by the attending physician detached for use as the buria 9 Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 → Inknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1. Natural 5 Pending investigation • Hospital or At., hours after death. • I Director: A^e hy the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the To the within ? To the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOREH GREENE ST. -DUSHES1+ BALTIMORE, MD ZIZU 22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** William 3 3 2008 0:10 White, Jr a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick N/H Baltimore N/A 8. Date of Birth (Month, Day, Year) 6-25-1937 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral 1**√2 M 2 □ F 70 N.C. Director 244-54-4206 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location r 28a-f show notified at 10b. County 1 **∑**Yes 2 □ No Funeral Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 3514 Elmora Avenue 21213 S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2√2 No Specify: Black Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Bethlehem Steel College (1-4or 5+) Elementary/Secondary (0-12) the 12th grade Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H Be William White, Carol Plummer ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lenora White - Wife 3514 Elmora Avenue Baltimore, MD 21213 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Cemetery3-7-2008 Parkville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR ACCIDENT Unknown /Medical Due to (or as a consequence of): PNEUmonia Examiner Unknow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or es a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the | attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy performed 1□ Yes 2 **□** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To After this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? • Hospital or Attending Pl 24 hours after death. • Funeral Director: After the (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral C 1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

29a. Certifier

30. Name and and

29b. Signature and title of certified

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31. Date filed (Month, Day, Year)

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MD son who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0059056

29d. Date signed (Month, Day, Year)

21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day .20 PM **Physician** WASHINGTON 2008 CIN Marien /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne South Rehabilital rever Edgewale | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 04/07/1954 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2**X**) F 53 Pennsylvania 221-32-3013 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2 XNo notifled Director 28a-f Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò must be United States 21037 1636 Elkridge Drive 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 □ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rehabilitation Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Health Medical Assistant 1 and 2 should be filed wi Health and Mental Hygien I**m 27 is marked other th** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl David Simpson Betty May Seller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is 1
any injury or other traur 1636 Elkridge Drive, Edgewater, Maryland 21037 Devon L. Washington/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Garden 03/08/2008 | Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Juneral Service Livensee 22. Name and Address of Facility George P. Kalas Funeral Home Mile Millell 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Comcer Endometrial **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the 1 as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 Ø No 4□Pregnant at time of death 5 Other (specify) P.O. the a 9□Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? ate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/2 No certificate Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To his 28d. Describe how injury occurred al or Attending Ph after death. I Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

And medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier ٥ MI culu D0053709 51h 2008 Marich

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 32. Registrar's Signature

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1CA)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sharon jarner 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY BAYVIEW BALTIMORE JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Months Hours Min. 1 □ M 2 🕱 F 212-16-1428 Feb 2, 1952 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Nes 2 No items 23a or 28a-f sh Iner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 Oldham USA 123 permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 DISABLED DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GENEVA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GUARdiAN 723 5. BAltimore Audrey Sister 75 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenword Center March 11, 2008 BAHIMORE,

22. Name and Address Facility

TOSEPH N ZANNINO TR. FUELD IN

26.35. Conkling St BAHO MD 2 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses Kerl arenen Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) 2 days **Physician** Influenza /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Syndrome Down 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records. within 24 hours after ucc....

To the Funeral Director: Aft the Hospital

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Medical

Doctor

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Palgniappan Ganesh Muthappan, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore Mayland

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)



and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 4, 2008 2:58 Рм Dorothy Wadsworth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F 214-03-0263 Director 18,1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Marylan 28a-f shov notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? ms 23a or 7 1808 Worthington Heights Parkway 21030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☐ WNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 2 3 Widowed 4 ☐ Divorced White Completed marked other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ G. Young Cray Joseph Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Stephen Wadsworth Son 1812 Worthington Heights Parkway Cockeysville, MD 20b. Place of Disposition (Name of semetery, crematory or other place)
Saters Baptist
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State = 5 Important: If any injury or once. 4 Donation 5 Other (Specify) <u>3-12-2008 | Brooklandville Maryland</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 مىر 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed PLEURAL EFFUSIONS and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To . Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hoi To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

State

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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PETER

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00025538

8320 BELLONA AVE SUITE 120 TOWSOMM021294

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 07 2008 **Physician** аМ 1:45 Mary Н. Waterburv March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Broadmead Baltimore Cockeysville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign
 Country) 8. Date of Birth (Month, Day, Year) May B, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Pennsylvania 185-20-6501 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral', or items 23a or 28a-f shov Examinar must be rediffed at Cockeysville 1 ☐ Yes 2 ☑ No Md. Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21030 13801 York Rd. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2√2 No White Specify. 3 ☑ Widowed 4 ☐ Divorced the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mentai Anna Law Dwiaht J. Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 215 Woodbrook Lane Baltimore, Md. 21212 Mr. William Paternotte∕ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 № Burial 2 Cremation 3 Removal from State Pikesville, Md. 3-11-08 Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 Yerk Rd. Towsen, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Due to (or as a consequence of): 68760. Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 0 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Records, 3 ☐ Probably 4 🖫 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 2 🗹 No 1 Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Dursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes o this 28a. Date of Injury (Month, Day Year) 27. Mannu of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospitel or Attending 5 Pending investigation 1 Inatural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 5, 2008 2:15 P /Medical 4c. County of Death 4a. Facility Nam of not institution, give street and number, Examiner Morningside House of Laurel Prince Georges Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 27, 1918 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F West Virginia Yrs 89 Director 233-09-6021 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🕅 No Directo Prince Georges Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 USA 7700 Cherry Lane, Apt 10 by Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 2X No 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dog Groomer Pet Grooming 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Collins George Hall ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 760 Ripplebrook Dr., Culpepper, VA 22701 Bette Ferrell- daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemtery 3/11/08 Brentwood, Maryland 4 Donation 5 Dother (Specify) 21, Signature of Furnal Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. M012 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseause or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 10 24a. Was an 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 20 No 2 ☐ ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 4 Nursing Home Medical Certification: To 1 ☐ Yes 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined I 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Montil, Day, Year) 29b. Signature and title of certifier who com 32. Registrar's Signature 31. Date filed (Month. Day. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Alexander Steven Martin 4:55 P.M February 23, 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Emmitsburg Frederick St. Catherines Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F Dec. 6, 1919 Pennsylvania 212-14-6966 88 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Frederick Thurmont 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21788 USA 15663 Kelbaugh Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction/Building Construction Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) C. Zimmerman Alexander Martha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clarence Shriner/Nephew 15706 Kelbaugh Road, Thurmont, Md 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 XOther (Specify) Entombment Resthaven Mem. Gards 2/27/2008 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition 5 118 Fre 2 18 N. 2 - 11/2 Cold (Cla)

Physician /Medical Examiner

Examiner

Physician/Medical

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Be Completed

Certification:

Medical

Physician

/Medical

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10a. State

Funeral

Director

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Baltimore, Maryland 21215-0036

attending physicien and for use as the burial-transit ed by the a been sign s certificate has b lirector, page 2 st : After this certification funeral director. il or Attendin after death. I Director: Afi d in by the fur To the Hospital or Atts within 24 hours after de To the Funerel Directo completely filled in by the

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

resulting in death)	Due to (or as a consequence	uence of):	er e caracre	July af CI	9 57		
Sequentially list conditions,	Myeraic	dial v	factio	r.	3414		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of the consequence of t	10 years.					
resulting in death) Last	Due to (or as a consequence of the perf	uerice of):	r.		30ym		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of de	I death 3 ☐ Ectopic			23d. Date of delivery Month Day Year		
Part II. Other significant conditions con	tributing to death but not rest	ulting in the underlying	cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown		
Drostall	Conce	(24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
2 . Was case refer d to medical examiner?			26. Place of De	eath (Check only one)			
1 □ Yes 21 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	OA Other: My Nursing	Home 5 Residence	6 ☐Other (Specify)		
27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	nry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the cause(s curred at the time, date and) and manner as stated. d place, and due to the cause(s)		
29b. Signature and title of certifier	omfel &	extreme?	9c. License number	7 02	te signed (Month, Day, Year) -74-7008		
30 Name and address of person who co	mpleted gause of death (Item	233) (1480 (201)	121-123 Emmits	west ma	1D 7077		
21 Date (iled (Month, Day, Vone)	30 Paintenda Cigna	turo d					

State Registrar 31. Date filed (Month, Day, Year)



			For State of Mary State Registrar		artment of Heal <i>rtificate of Dea</i>		Hygien	ZHHB	07641		
	Physici		1. Decedent's Name (First, Middle, Last) John A. Abend, Jr.			2. Date Monti Febru	_	3, 2008	3. Time of Death 4:15 P M		
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 20879 Freedom Run Drive		4b. City, Town, or Loca Lexington F	ation of Death	40	4c. County of Death St. Mary's			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday) 72 Yrs.	If Under 1 Year If U	Inder 24 Hrs. 8. Date	of Birth th, Day, Year	9. Birtho	place (State or Foreign		
	yland now at		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	cation			1	0d. Inside City Limits		
	he Mar 8a-f sh otified	Director		Lexingtor					1 □ Yes 2 No		
	3a or 2		10e. Street and Number 20879 Freedom Run Dr.		10f. Zip Code 20653		US.	itizen of What Cour A	itry?		
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fire X7 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:		Nas Decedent of Hispani f Yes, specify Cuban, Me 1 □ Yes 2 🌣 No Spe		or No-	14. Race - Americ Black, White, Specify: Whit	etc.		
2-00	72 hou natura dical E		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during	n most of working	16b. l	Kind of Business/In-			
Baltimore, Maryland 21215-0036	within iene. than " the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	`life. I	(life. DO NOT use retired) Carpenter			nstructio	าก		
nd 2	al Hygi d other vent, t	Be C	17. Father's Name (First, Middle, Last)	1 Carp	·	Mother's Name (First, M			<u></u>		
ryla	hould to Ment to Market market	2	John A. Abend, Sr. 19a. Informant's Name/Relationship (Type. Print)	19h Maitir			Marie Reider r Rural Route Number, City or Town, State, Zip Cod 20653				
, Ma	and 2 salth an 27 is ser traus		Barbara L. Abend/Wife		20879 Freedo			gton Park			
ore	ges 1 and to file it of He or other		1 █ Burial 2 □ Cremation 3 □ Removal from State	_	natory or other place)	Date	ŀ	ocation - City or To	·		
ıltim	nit. Pa artmen ortant: injury e,		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service-Licensee /		en Mem. Park Name and Address of R			n Burnie, 1 Home	MD		
ä	Dep Imp		Men Kalar	65	12 NW Crain	Hwy. Bowi	ie, MD				
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	8 2 2	Completed	, , , ,			24a.	Was an autopsy performed? Yes 2₩N	prior to co death?	ppsy findings available mpletion of cause of		
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100	g Physier this	n: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatien 28b. Time of Injury	1 3 DOA 41	□ Nursing Home 5 🔀	Residence cribe how inj		(y)		
Sior	Attending Physician: r death. ector: After this certifica by the funeral director, I	Certification:	2 Accident investigation		M 1 ☐ Yes						
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1	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of ex and manner stated	amination and/or in	n occurred at the time, da vestigation, in my opinior	ate and place, and due to n, death occurred at the	time, date a	s) and manner as s nd place, and due t	stated. o the cause(s)		
,	Vith Con	2	29b. Signature and title of certifier		29c. License num			ate signed (Month,			
2	(6)	-	30. Name and address of person who completed cause of death	n (Item 23a) (Type,	Print)			- 10 -			
	(5)		Dr Mukhtar Hassan P.O. Box 5.	27 2550	o Pt. Lookow	tRd 1800	ardtoc	un Md.	20650		

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John

			For State Registrar	State of	f Marylan		artment of <i>rtificate o</i>				giene	108	07642
			Decedent's Name (First, Middle	e, Last)					2	2. Date of Dea Month	ath Day	Yeer	3. Time of Death
	Physici /Medio		Stella Mae Absi	rire					F	eb.	28	2008	06:10 AM
	Examir		4a. Facility Name (If not institution	n, give street and nur			4b. City, Towr	n, or Location	ol Death		4c. Coun	ty of Death	
			Harford Memoria				Havre o					ford	
ı	Funeral Director		5. Social Security Number 219-16-4857	6. Sex 1 □ M 2/CX F	7. Age (In yrs.	92 Yrs.	Il Under 1 Ye Months Day		Min.	B. Date of Birth (Month, Day arch 8	v, Year)	Coun	lace (State or Foreign htry) Junia
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	0d. Inside City Limits
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cer	3a or	I D	3438 Cedar Chw	rch Road			21034	4			u.s.A.		
0	death	Funerai	11. Marital Status		edent Ever in U.	.S. 13.	Was Decedent of If Yes, specify C	ol Hispanic O	Origin? (Spec	ify Yes or No-	14. R	ace - Americ	
1 4	or He	F	1 Never Married 2 Marr	ied 1 ☐ Yes	2 No		1 Tes 2			10011, 010.7		ity: Whi	
\$ 6	ural',	d by	3 Widowed 4 □ Divorced	Year or D	ates:	1 10 5							
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12	Hygi ent.	Be C	17. Father's Name (First, Middle,	Last)		0000	rig macero.			First, Middle,			
2	id be fental ked ic ev	To B	Wiley Monroe B	aldwin				Rose	a Weav	er			
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	and 2 and 2 ealth a n 27 ic		Deborah J. Col	lopy (Daug									land 21034
Expired Solitons	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show apply injury or other traumatic event, the Medical Examination in collined at once.		20a. Method of Disposition 1	3 Demoval from	State 20b. P	Place of Disponentery, cre	osition (Name of matory or other	place)	Da		20c. Location		
W E	Pages ment of Pant. If Its		4 Donation 5 Other (S		Har		Mem. Ga						vryland
***	Dennit. Departimont import		21. Signature or Funeral Service	Licensee	TI		2. Name and Ad					-	
	4 707 9 a		60.									race,	MD 21078 Approximate
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00	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregr 9⊟Unkn	nant at time of d own	leath 5	Other (specify	")					
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2.4	00	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🖫	Inpatient 2	ER/Outpatie	nt 3 DOA	Other		e 5 ☐ Resid		Other (Speci	fy)
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2.4	Attending or death.	atlc	2 ☐ Accident invest	gation				1 Yes 2					
Shine	i or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place build	of Injury - At hi ing, etc. (Specif	ome, larm, si fy)	treet, factory, off	ice	2	8f. Location (3 City or Tox		mber or Rur	al Route Number,
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	\circ		30. Name and address of person	who pleted cau	se of death (Iter	ท 23a) (Type	Print)	, ,		,	1.00	2	
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		ate	31. Date filed (Ment Pay, Year	2008 325	Registrar's Signa	ature	2 00						
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Registrar

31. Date filed (Month, Day,

ORIGINAL

32. Registrar's Signature

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		4	For State Registrar	State of Mar		ertificate of L		lental Hygie	2000	07644	
			Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic	_	IRENE	М. В	ROOKS			February	25, 2008	6:30 P M	
	Examin	20	4a. Facility Name (If not institution, give FRIENDS NURSING F				SPRING		4c. County of Dea	RY	
	Funeral Director		215-60-9354	7. Age	(In yrs. last birthda) 86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) May 17		thplace (State or Foreign ountry) Ingland	
	faryland show		Usual Residence of Decedent 10a. State 10b. County Md. Montqu		10c. City, Town or	_ocation Spring				10d. Inside City Limits 1 Yes 2 No	
	with the h	i Director	10e. Street and Number 15550 Prince Free	derick Way		10f. Zip Code	20906	10g	Citizen of What Country? United States		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show appringing or other treumatic avent, Ira Madical Establical must be notified at anone.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:		. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:		
21215-0036	vithin 72 hounde. Nen *natura Nevical	Completed	15. Decedent's Ed (Specify only highest gra-		edent's Usual Occupa re kind of work done o DO NOT use retired Iomemaker	luring most of work	b. Kind of Business	·			
and 5	d be filed vental Hygie	To Be Co	12 17. Father's Name (First, Middle, Last) George Godleme	18. Mother's Name	ne (First, Middle, Maiden Sumame) Ada Grace						
Maryland	id 2 shoul Ith and Mi 27 le mari treumati	F	19a. Informant's Name/Relationship (7) Denise M. Vernon			iling Address (Street a				Zip Code) 20832	
Baltimore,	Pages 1 an ent of Hea nt: If item ? ry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify			position (Name of ematory or other place plitan Cres	θ)		c. Location - City o		
Balti	permit. I Depertm Importa any inju		21. Signature of Funeral Service Licen **Murrif** #.			22. Name and Addres	s of Facility	Funeral E Laytonsv:	Home 111e, Md.	20882	
Ġ	Physician		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	he death. Do not e ioma	nter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death	
8	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
0	outed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):						
8760,	cate be executed bhysicien and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
.O. Box 68	death certifii e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			23d. Date of do	elivery Day Year			
<u>α</u>	law requires that the de as been signed by the a r 2 should be detached f	6	Part II. Other significant conditions of	ontributing to death but	en in Part I.		acco use contribute to the cause of death? s 2 (Xno 3 Probably 4 Unknown				
Division of Vital Records,	: The law require cate has been si page 2 should I	Completed				24a. Was an autopsy performe	autopsy performed? performed? death?				
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		inst 3C DOA Oth		th (Check only one)			
on of	ding After fune	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time	of 28c. Injun	4 (A) INUISING IN	ome 5 ☐ Residen 28d. Describe how		ecity)	
Divisi	or At	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined		ry - At home, farm, (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or At within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one) 1 Cartifying Ph 2 Madical Exam	ysician: To the best of niner: On the basis of and manner stat	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occui	and due to the cau red at the time, dat	se(s) and manner a e and place, and di	as stated. ue to the cause(s)	
	Within To th comp	Me	29b. Signature and title of certifier	,1	, , , ,	29c. Licens	e number	290	d. Date signed (Moi	nth, Day, Year)	
)			· name	will	day	DO	06008	9	2/26/1) F.	
	10		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	e, Print) ecticut Av	n #202	Silver	Spring N	id. 20906	
90	Sta	ite.	Ramani B. Reddy 31. Date filed (Month, Day, Year)	20 Barriotett	do Cianatura		Ε., πΖΟΖ	, DIIAGI	~~~~~~		
	Regist		FEB 2	7 2008	aves de	Garie					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February 21, 2008 1:15 p **Physician** Maria Teresa Beane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Bowie Health Center Bowie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year Months Days Hours 1 □ M 24□ F 14, 1937 Argentina 579-72-6535 70 Aug. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 🕱 No Director Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number IISA 20720 Funeral 12012 Ouartette Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11. Marital Status Black, White, etc. Examiner permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: I item 27 Is marked other than "natural", or ite any finlury or other traumatic event, the Medical Examine 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1√2 Yes 2□No Specify: Argentinian White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Laundry Proprietor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Petra Isabel Macero Mateo Altamirano ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12012 Quartette Lane, Bowie, MD 20720 Petra J. Beane-Moore/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 23, 1 ☐ Burial 2 K Cremation 3 Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd., W., Silver Spring, MD 20901 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or comblicat shock, or heart failure. List only one of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or in jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 2 🔀 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 → No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 🖳 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760 within 24 hours a 0

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier d addrage of person who completed cause of death (Item 23a) (Type, Print) 30. Nam 1221 Mercantile Lane, Largo, MD coles M Na Glen

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 26 2008

29a. Certifier

Registrar's Signature

		-	For State Registrar	ate of Maryland		tificate of L			No. 2008	07646
	Physicia	an	1. Decedent's Name (First, Middle, Last) MARY AND	N BRIGH	т			2. Date of Death Month FEBRUARY	Day Year 24 2008	3. Time of Death 11:20 P M
	/Medic Examin	A . 18 . 18	4a. Facility Name (If not institution, give street				Location of Death	FEDROARI	4c. County of Death	
			817 SOUTH CAMPE MEA 5. Social Security Number 6. Sex	ADE ROAD 7. Age (In yrs. las	t birthday)	LITHICU	JM If Under 24 Hrs.	8. Date of Birth	ANNE ARU	place (State or Foreign
	Funeral Director		579-38-5074 1□M 2		Yrs.	Months Days	Hours Min.	Month, Day, Ye DEC 2 19		SHINGTON, DC
and a	pur M		Usual Residence of Decedent 10a. State 10b. County	10c. City, 7	Town or Loc	ation				10d. Inside City Limits
	Maryla -f sho fied at	tor	MD PRINCE GEORG	GE'S LA	NHAM					1 XYes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. The Beath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show defect traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5407 85th AVENUE			10f. Zip Code 20706		10g.	Citizen of What Cou USA	intry?
	ems 2	ınera	A A	as Decedent Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
22	ours after ral", or ite Examine	by	1 ☐ Never Married 2 【 Married 1 If 3 ☐ Widowed 4 ☐ Divorced Y	□Yes 2 🔯 No Yes, Give ear or Dates:	1	□Yes 2∏XNo	Specify:		opeany.	BLACK
5	"natu edical	letec	15. Decedent's Education (Specify only highest grade con	pleted)	(Give I	ent's Usual Occup kind of work done o O NOT use retired	durina most of work	ing 16	b. Kind of Business/li	ndustry
7 7	d within giene. r than the Ma	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	HOUSE				PRIVATE	
2	be filed tal Hyg d othe	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Surname)	
Ž	2 should and Men is marke raumatic	욘	WESLEY WELLS 19a. Informant's Name/Relationship (Type. P	rint)	19b. Mailin	a Address (Street		E QUEEN	City or Town, State, Z	ip Code)
2	⊕ £ ∧ ≟		CHARLES BRIGHT SR./I					M, MARYLA		
10 10	Pages 1 a nent of Hea int: If item iry or othe	1	20a. Method of Disposition 1 Burial 2 Decremation 3 Remove 4 Donation 5 Other (Specify)	autrom State I		sition (Name of natory or other place E CREMAT	ORY 2/27/		c. Location - City or T	
חשוו	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	(0	22	. Name and Addre	ss of Facility	. в. JENK	INS FUNERA ,MARYLAND	AL HOME 20785
: ::::::::::::::::::::::::::::::::::::	Physician [®]	8 7	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final	ns that caused the death. use on each lin.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (r as a conseque	nce of):	· C/ C	0~ 117	,		
P	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to for as a conseque	nes off:					
Ć,	icate be executed physician and s the burial-transit	I Examiner	that initiated events c c	Due to (or as a conseque	nce of):		·			
00/00	ficate I physics the k	edical	d							
J. DOX	The law requires that the death certificate be executed tte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	yes, outcome pf pregnand □Live birth 2 □ Fetal d □ Pregnant at time of dea □ Unknown	leath 3□	Ectopic pregnanc Other (s <i>pecify</i>)	у		23d. Date of deli Month	very Day Year
Ţ	that the		Part II. Other significant conditions contribu		ing in the ur	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords,	equires en sigr	ed by	End Stage RAN	al Distrol				1 🗆 Yes	2No 3□ Pr	obably 4 □Unknown
200	The law re te has bee age 2 sho	Completed						24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of
VII	stan:]	Be C	25. Was case referred to medical examiner?					th Check onl one		
0	Physic this ceral dire	မ	1 ☐ Yes 2x No	1 Inpatient 2 E	R/Outpatien	3 DOX		ome 5 Residen	ce 6 XOther (Spe	cify) HOSPICE
0	th. ; After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No		,,	
DIVISION	al or Atter after dea I Director d in by the	Certification:	- Tarris GT Could not be	Be. Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	edical C	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination	ledge, deatl on and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	, and due to the cau irred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	with		29c. Licens			d. Date signed (Mont	
١			1 Carr	of the	~		31557	<i>F</i>	PATHON	26,200f
Ω	[7]	1	30. Name and address of person who comple	eted cause of death (Item 2	∠3a) (Type,	rrint)				

cf (2)

31. Date filed (Month, Day, Year) FEB 2 7 2008 State Registrar

RUSSELIP DELUCA M.D. 305 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 32. Registrar's Signature

3H-5

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) FEB 2 7 2008

nancisco



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	•	For State Registrar	State of Mar	yland / [rtment of H Fificate of L			giene Reg. No.	71HHR	07649
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
/Medic	al 🗉	John Lincoln Best 4a. Facility Name (If not institution, give	atmat and number)	,		4b. City, Town, or	Location of Dogt	Februai		2008	1:30 AM
. Examin	er	Northampton Manor		ome		Freder		"		ederick	
Funeral Director		5. Social Security Number 6. Se 269-30-5760		/In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days			th	9 Birthr	place (State or Foreign ntry) 1and
and w		Usual Residence of Decedent 10a. State 10b. County		I0c. City, Tow	n or Loc	ation		 _		1	10d. Inside City Limits
Mary a-f sho fied a	ţo	Maryland Frederic	k	Sabil	lasv	ille					1 ☐ Yes 2 ☑ No
or 282	Directo	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
s 23a nust b	ral	17064 Harbaugh Val	ley Rd. 12. Was Decedent Ev		140.18	21780	·			ed State	
in the young you have a second of the many second of the s	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	as Decedent of Hi Yes, specify Cuba □ Yes 2점 No	spanic Ongm? (3 in, Mexican, Puer Specify:	to Rican, etc.)	<i>-</i>	Black, White,	
72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a	. Decede	ent's Usual Occupi ind of work done of O NOT use retired	ation during most of wo	rking	16b. Kii	nd of Business/In	dustry
within sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		_	o not use retirea aper)	Ü	Lan	decape C	Construction
filed Hygid	Be Co	17. Father's Name (First, Middle, Last)		La	iiusc	aper	18. Mother's Nar	ne (First, Middle	L		<u>onseruction</u>
uld be Wental Mental Irked o	To B	John W. Best					Ethel I	Lowe			
y interpretation of the state o		19a. Informant's Name/Relationship (7) James Best / Son	vpe. Print)	17	064		Valley				^{o Code)} MD 21780
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1. □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)		20b. Place of cemeter Remote Memorial	rial	ition (Name of atory or other plac aven Gardens		2008	Fred	cation - City or To lerick, N	Maryland
permit Depar Impor any in		21. Signature of Foreral Service Licens	see		Re	Name and Address thaven	Funeral	Services	s, Sk	kot Cody	y P.A.
Physician		23a. Pant. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition			not ente	01 Catoc r the mode of dyin	g, such as cardia			ick, m	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a			25011					
2.05	e.	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	consequence	of):						
cuted id ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.								
icate be executed physician and sthe burial-transit	EX	resulting in death) Last	Due to (or as a	consequence	of):						
cate b	edical		d								
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tii 9□Unknown	Fetal death		Ectopic pregnancy Other <i>(specify)</i>	,		2	23d. Date of deliv Month	rery Day Year
that the the that the the that the that the that the that the the the the the that the the the the the the the the the th		Part II. Other significant conditions co	ntributing to death but	not resulting i	n the und	derlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute to t	the cause of death?
en sign	ed by		- 12-1					1 🗆	Yes 2	Q No 3□ Pro	bably 4 □Unknown
The law re te has be age 2 sho	Completed								psy ormed?	prior to co	opsy findings available ompletion of cause of
ian: '	Be C	25. Was case referred to medical examiner?					26. Place of De	1 Yes ath <i>(Check only</i>	2 No one)	1 10163	2010
hysic this ce	2	1 ☐ Yes 2 10 No	Hospital: 1 ☐ Inpatient		·		4 Nursing F			6 □Other (Speci	fy)
ding P	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		Time of Injury	28c. Injur Worl	y at k? Yes 2 ⊡ No	28d. Describe	how injur	y occurred	
al or Attendation of in by the	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, fa (Specify)	arm, stre		703 2 110	28f. Location (City or To	Street an wn, State	d Number or Run)	al Route Number,
ne Hospit. 1 24 hours ne Funera	Medical C		rsician: To the best of iner: On the basis of e and manner state	xamination a							
To the within To the company	M	29b. Signature and title of certifier	7			29c. Licenso	e number 3091		29d. Dat	te signed (Month,	Day, Year)
		30. Name and address of person who describes the second se	ompleted cause of dea	ath (Item 23a)	(Type, P	rint)	House	Ane,	Fre	derich	, MD
Sta	_	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		1 1					
Registr OHMH 17 Rev 1/20	- 1	FEB % 7	ZUUB THE	a A	E E						

			For State Registrar	State of Ma	•	epartme Certifica			Mental Hy	giene	1000	07650
			Decedent's Name (First, Middle, La	st)	•				2. Date of D	eath		3. Time of Death
	Physici		Edmond Lockwood B	outon, Jr.					Month 2	25 ^{Day}	2008	4:38 P M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. C	ity, Town, or	Location of Deat			County of Death	
	- Admin		Atlantic General	Hospital		Ве	erlin				Worces	ter
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birti		der 1 Year	If Under 24 Hrs Hours Min.	8. Date of B	irth	9. Birth	nplace (State or Foreign
	Director		370-03-4001	X M 2□F	89	rs.	is Days	110uis IVIII1.	8. Date of B (Month, D 5/23/1	918		VA
	D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Logation						10d. Inside City Limits
	h the Marylan r 28a-f ehow r notified at	5			-							1 ☐ Yes 2 🔀 No
	he M	ectc	MD Worcest 10e. Street and Number	er	Ocean_		Zip Code			10- 04	izen of What Co	
\$		Funeral Director								1		uritry:
2	seth se 23	era	10 Hidden Lake Ct	12. Was Decedent E	Ever in II S		21811	ispanic Origin? (9	Specify Ves or N		SA 14. Race - Amer	rican Indian
200	iter d	E	1 Never Married 2 X Married	Armed Forces?				ispanic Origin? (S n, Mexican, Puer	to Rican, etc.)		Black, White	
35 036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 □ X No	Specify:			Specify: W	hite
760:2135R	within 72 hours after desene. then "natural", or freme he Medical Examinar m	Completed	15. Decedent's E. (Specify only highest gra		16a.	Decedent's U	sual Occupa	ation during most of wo	rking	16b. Ki	ind of Business/l	ndustry
760:2135168 1438 21215-0036	thin 7	ple.	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NO	Tuse retired))	ikiig			
	000	Son		4		lgent					ernment	
- ID	be filed ttal Hygie of other event, t	Be	17. Father's Name (First, Middle, Last	•				18. Mother's Na		e, Maiden	Sumame)	
and 89M yland	should Ind Men	ဥ	Edmond L. Bouton					_Blanche				
Bowton, Edmond 106 5/33/1919 89M Baltimore, Maryland	s i and 2 should be filed within 72 hour f Health and Mental Hygiene. Item 27 is marked other then "natural other traumatic event, the Medical E		19a. Informant's Name/Relationship (and Number or Ri				
B) (E)	1 and 1eaith em 27 ther tr		Doris I. Bouton /	wite	20b. Place of			e Ct., (Jcean Pi		MD 218.	
No.	in tof h		1 Burial 2 XCremation 3		cemetery	r, crematory o	or other place				,	
ting ting	t. Pa rtmer rtant:		4 Donation 5 Other (Special		Cape F	lenlope					nkford,	
Bowton, Echmond 1006 5/33/1918 891 Baltimore, Marylar	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other tra ance.		21. Signature of Funeral Service Licer	Cont of				ss of Facility T				Home
			23a. Party. Enter the disease, or com	plications that caused	the death Do n			m St., E			1011	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.				o or roopiratory	arrost,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		ironic f		Faile	ire				
	Examiner			Due to (or as	ngestwe	1100	+ F	2 1				
		er	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a c sequence o		r (1)	nime				
	be executed sictan and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. V	Joular	Hear	7 DI	sease				
ó	exec an an rial-tr	Exa	resulting in death) Last	,	a consequence o	f):					- 1	
8760,	ate be executed hysician and the burial-transli	dlcal		dCÌ	nonic	Anev	ma					
9	ntifica ng ph as th	Med	IE EE WALE									
Вох	eath certifi attending I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopic	pregnancy			1	23d. Date of deli	
Э.	e dea	SICI	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐ Unknown		5 🗆 Other					Month	Day Year
P.O.	Attanding Physician: The law requires that the death certific rebeth. c deeth. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	9 Unknown						20. 014			de a como el de oblo
တ်	res that igned to be det	<u>م</u>	Part II. Other significant conditions	ontributing to death bi	ut not resulting in	the underlyin	g cause give	en in Part I.				the cause of death?
ord	w requii been s should	ted							1	Yes 2	□No 3□Pro	obably 4 2 Unknown
ec	alaw nasb	Completed							24a. Wa auto	opsy	24b. Were au prior to d	topsy findings available completion of cause of
<u> </u>	The lay	Son							1 ☐ Yes	formed? 2-100	death?	2□ No
Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			0#		ath (Check only			
of	Physi this c	ဥ	1 Yes 2 No	Hospital: 1 Inpatie		patient 3		er: 4 ☐ Nursing I				city)
, L	ding f	o	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Ti	jury M	28c. Injury Work	γατ c? Yes 2 □No	28d. Describe	now injur	у оссигеа	
isic	deeth deeth stor: / the	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e Diago of Init	Inv. At home for			162 2 110	28f. Location	(Street an	id Number or Bu	ral Route Number.
Division of Vital Records, P.O.	after Direct in by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	m, street, rac	tory, office			own, State		rai noble rainber,
_	spital ours seral filled	2	29a. Certifier 1 Certifying Pt	ysician: To the best of	of my knowledge	death occurr	ed at the tim	ne date and place	and due to the	a cause(s)	and manner as	stated
	24 h 24 h Fur etely	edical	(Check only 2 Medical Examone)	ninar: On the basis of and manner sta	examination and	Vor investigat	ion, in my of	pinion, death occ	urred at the time	, date and	place, and due	to the cause(s)
_	To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier				29c. License	number		29d. Da	te signed (Monti	h, Day, Year)
	- > F 0) Grann	fre Att	endm	_	D54	3/2		02/2	5/2008	
		1	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)				1		
8.	T 6+1		A	nuas, MD	eath (Item 23a) (9733 ar's Signature	Health	may D	have Ber	lin, mi	218	31)	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1	1	-	,			
	Registr	ar	FEB 2 7 2	008 1800	se Si.	1034						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Martha Hiett Blasier february 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun 13, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Illinois 1923 377-22-9798 84 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Mitchellville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10450 Lottsford Road # 5009 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ^{Specify:}White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Speech/Language Therapist Education/Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Earl Hiett Edna McMillen P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10450 Lottsford Rd. #5009 Mitchellville, MD 20721 Cole Blasier/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X1 Cremation 3 ☐ Removal from State Chesapeake Crematory | 02/23/08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licens 21. Signature Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a Acute Multifocal Stroke /Medical Due to (or as a consequence of): Examiner b. Dementia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and c. Hypertension Due to (or as a consequence of): -burial Box 68760. attending physician for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed this certificate 2 11No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24

State

DHMH 17 Rev 1/2001

2 6 2008 Registrar

29b. Signature and title of certifier

D.

31. Date filed (Month, Day, Year)

George

32. Recistrar's Signature

7500 Hanover

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

29c. License number

MDD 58182

29d. Date signed (Month, Day, Year)

Parkway, Suito #101A, Greenbelt, MD. 20770

			1- For State of Maryland / Department of Certificate of		giene 008 07652
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Paulino A. Banda	2. Date of De Month Fch mu	my 25 2008 12.40 km
	Examin			or Location of Death Ott City r If Under 24 Hrs. 8, Date of Bi	' 4c. County of Death Howard th 9. Birthplace (State or Foreign
	Funeral Director		241 03 4810 1 M 2X F 88 Yrs. Months Days Usual Residence of Decedent		1919 North Carolina
	r 28a-f show	Director	MD Howard Ellicott City 10e. Street and Number 10f. Zip Code		10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country?
936	within 72 hours after death with the Maryland one. than "natural", or Itams 23a or 28a-1 show he Mudical Erai: in et mast be routified at	by Funeral	9910 Old Annapolis Road 2104 11. Marital Status	Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.)	United States 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	TO TO NOT THE	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	a during most of working	16b. Kind of Business/Industry Own Home
yland	be d d	To Be (Aaron Finley Pearcy	18. Mother's Name (First, Middle Etta Mae Lowman	
_	alth a	1 100	Charles V. Banda, Jr. 9906 Old Ann	Date	cott City, MD 21042 20c. Location - City or Town, State
Baltimore,	permit. Pages 1 a Department of He Important: If itam any injury or otha		1X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Crest Lawn Mem.	Gard. 2-27-2008	Marriottsville, MD itzke's Family FH Inc.
B	e d m e d		The Bodd Fator the disease or complication that accord the death. Do not enter the mode of the	ing such as andias or recairatons	licott City, MD 21043 Approximate Interval Between Inset and Death
8760,	/Medical bhysician and bhysician and the burial-transit the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	nentia	way to person
O. Box 6	the death certif the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 To 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	су	23d. Date of delivery Month Day Year
Δ.	law requires that th as been signed by 2 should be detac	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Hinknown
Vital Records,	The ate h	Completed		1 ☐ Yes	prior to completion of cause of death? 2 \(\text{Ves} \) 1 \(\text{Yes} \) 2 \(\text{No} \)
Division of Vit	Attanding Physician: 1 r death. actor: After this certifical by the funeral director, p	atlon: To Be	27. Manney of Death 1. Matural 5 Pending (Month, Day Year) 1. Matural 5 Pending (Month, Day Year) 1. Matural 5 Pending (Month, Day Year)	ther: 4 Nursing Home 5 Resury at 28d. Describe ork?	
Divis	in the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Rural Route Number, wm, State)
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	29a. Certifler (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	oninion, death occurred at the time	date and place, and due to the cause(s)
) ~	To To		Signature and title of certifier)30641	February 25 2008
6	900		29b. Signature and title of certifier 29c. Licer 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) Auman Sahapan 201-105 Sack 16 31. Date filed (Month, Day, Year) 32. Regetrar's Signature	ived Neek Poo	rd Balhmore Marfaid
	Sta Registr	te ar	FEB 2 6 2008 Kleen & Spark		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] S 1 - For Stete Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 23, 2008 **Physician** 10:49 A M Mary Evelyn Brogan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harkord If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month Day 1912) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Maryland 212-18-7799 95 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or items 23s or 28s-f show the Madical Exeminar must be notified at Yes 2 No Director Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 105 O'Neil Court U.S.A. 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) i 1 end 2 should be fi Health and Mental H tsm 27 is marked oth Be ၉ Unbnown Matte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health 107 O'Neil Court, Havre de Grace, MD 21078 Al Brogan (Son) Baltimore, 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages Department of himportant: If its any injury or of once. 02/27/2008 Aberdeen, Maryland Harkord Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Eugeral Service License 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit Due to (or as a consequence of) Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 20 No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ No 1 Yes 2 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours DECERTIFYING Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Fun completely (Check only one) To th. within 2. To the FP 29b. Signature and title of certifier

State Registrar 30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

2008 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Mary Lee Bedsworth eb: 4a-Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death WICOMIC 56W Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 X F Yrs. 84 <u> 213-18-5382</u> 6/18/1923 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TxYes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 300 Amherst Road 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Deers Head Hospital <u>food service</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elva Thomas Harry Disharoon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Watson/daughter 1517 Marlboro Rd., West Chester, PA 19382 20b. Place of Disposition (Name of cemetery, crematory or other plac Wicomico Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/29/08 Salisbury, MD Park 21. Signature of Funeral Service nsee ²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Tall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CARCINDANA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ⊀o 24a. Was an 1 Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Examine Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ဥ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If lem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending

Beds Worth

attending physician and for use as the burial-trar director,

Physician/Medical

þ

Completed

Be

Certification: To

Medical

1 | Yes 2 | → No

27. Manner of Death

2 Accident 3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

> Natural

signed t cate has been sit, page 2 should b certificate has this n 24 hours after death, le Funeral Director: A sletely filled in by the fu

completely within 2

State Registrar

WARIS 6 Hussan 31. Date filed (Month, Day, Year)

FEB 2 6 2008

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1/Enpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

COASTAL HOSPICE

2 ER/Outpatient 3 DOA

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

000058410 02-23-08 POBOK 1733 SALISBURY NO 21802

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

			For L_ State	State of Ma	ryland		rtment of F		d Mental Hy	- 1	2008	0.7	655
			Registrar 1. Decedent's Name (First, Middle, Las	(f)	_	Cei	lilicale of	Dealli	2. Date of De	Reg. No. £	_ 0 0 0	0 1	of Death
	Physici		RHODA	,		BARTO	M		Month 03	Day	Year 2008	195	
35	/Medic		4a. Facility Name (If not institution, give	street and number)		Dilicit	4b. City, Town, or	r Location of De			County of Deat		,
	ZX	3*	WMHS-BRADD	OCK CAMPUS			CUMBERL	AND		AL:	LEGANY		
	Funeral Director		100-20-1000	ex 7. Age □ M 2□ x F	(In yrs. Ii 74	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Bi lin. (Month, Da Mar 1	o, 193	9. Birti Co	hplace (State untry) PA	or Foreign
and	>		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside	City Limits
Maryla	f sho led at	ō	MD Allega		,		nberland						es 2□No
n the	r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?	
th witl	23e o ist be		14709 Potomac	View Dr.				21502			USA		
r dea	er mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Vas Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)	D- 1-	4. Race - Ame Black, White		
36	", or I	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🕻 No If Yes, Give Year or Dates:	0		l□Yes 2□ X o	Specify:			Specify:	hite	
- 00 P	ntal Hygiene. cd other than "natural", or items 23e or 28a-f show event, the Medical Examiner must be notifiled at	ted t	15. Decedent's Ed	L lucation		16a. Deced	lent's Usual Occup	ation		16b. Kin	d of Business/		
215 Fin 73	e. Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+	-)	(Give life. L	kind of work done OO NOT use retired	during most of t d)	working				
21 ed wit	ygien er thi t, the	S	12	3+		Nurse	3				morial F	Hospita	1
and Be		Be	17. Father's Name (First, Middle, Last) Gusty Walters						Name (First, Middle 1 O'Neal		,	ntain	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland	th and Mental Hygi 7 is marked other traumetic event, 1	은	19a. Informant's Name/Relationship	Type Print)		19h Mailir	n Address (Street		Rural Route Numl				
S 5	har 7 is trau		H. Edward Barto		and				w Dr. Cur			MD 21	502
	of Health fitem 27 i rother tra		20a. Method of Disposition	1-	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Loc	ation - City or	Town, State	
Pages	ant: If ury or		1				e Cemetery		3/7/2008	Cr	esapto	wn	MD
Balt permit.	Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licen	10		22	Name and Addre Scarpe	ss of Facility Elli Funeral	Home, PA				
ш а				///		. D			nue: Cumberl		21502	Annrovin	ato
			23a Part Lenter the disease, or cord shock, or heart failure List only Immediate Cause (Final	•		i. Do not ent			diac or respiratory a	arrest,		Approxin Interval E Onset an	Between d Death
	ysician Medical		disease or condition resulting in death)	a. Panci Due to (or as a		+1C	Can	cer				mon.	thS
	aminer			Due to (or as a	consequ	derice ory.							
	\$0 2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	uence of):							
ecuted	nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		_							
50, Se exe	physician and the bunal-transit	ă	resulting in deality cast	Due to (or as a	consequ	uence of):							
58760, icate be e	physics the t	dical	•	d									
I Records, P.O. Box 68760, The law requires that the death certificate be executed	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnapt	23c. If yes, outcome p						2	3d. Date of de	livery	
death death	d for I	icia	in the past 12 months?	1 ☐ Live birth :]Ectopic pregnanc]Other (specify) _	у			Month	Day	Year
P.O	signed by the a be detached f	hys	9 ☐ Unknown	9□Unknown									
S, es the	igned be de	by F	Part II. Other significant conditions of	contributing to death bu	t not resu	ulting in the u	nderlying cause giv	en in Part I.			se contribute to		
ord requir	should b								_	Yes 2]No 3[]Pi	robably 4	Henknown
Vital Records, sician: The law requires the		Completed							— 24a. Wa:	s an opsy formed?	24b. Were at prior to death?	utopsy findin completion c	gs available f cause of
<u>a</u> =	ate Oac		OF Was and a state of the state						1□ Yes	2 No	1 ☐ Yes	2 □ No	
Vit	certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 🕞	ER/Outpatier	nt 3 DOA Oth	or:	Death (Check only ng Home 5 ☐ Res		Other (Spe	ocifu)	
o l	er this eral d	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	у	28b. Time o			28d. Describe			Cliy)	
Vision or Vital	death. ctor: Aft y the fun	atio	1 ☑Natural 5 ☐ Pending investigation	n	(ear)	Пјагу		Yes 2 No					
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oltal o			4 7 7 4 4 4 4 4 5	To the book	f l.m.a					(-)			
Div To the Hospital or	within 24 hours after death To the Funeral Director: completely filled in by the	Medical		nysician: To the best of miner: On the basis of and manner sta	examina								e(s)
o the	within 2 To the complei	Mec	29b. Signature and title of certifier	414 11411107 514			29c. Licens	se number		29d. Date	e signed (Mon	th, Day, Year	·)
	> P 0		1 Boul or	lela			D54	1411		MAR	CH 4	,200	28
			30. Name and address of person who	completed cause of de	eath (Iten	1 23a) (Type,	Print\		_				
			BEVERTY OCALK	ins M.D.	50	00 me	morial	Aven	ue, Cum	Der	land. 1	n_0, a	1502
11	Sta Regist	ate	31. Date filed (Month, Day, Year)	32 Registra	ır's Signa	llure			1				
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	1/2					Ø.							

ORIGINAL

be executed P.O. Box 68760. Division or Vital Records, death. Hospital or Attendl 24 hours after death. Funeral Director: A filled in by

filed within 72 hours after

3altimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 00062223

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PLAY66N BOLANUM MD , 196 TJ DEI

, 196 TJ Deive, PREDEMCE, MD

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 11

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title



DHMH 17 Rev 1/2001

To the Hospital within 24 hours at To the Funeral C completely filled is

			For	State of Maryla				Mental Hy	giene	0000000
			State Registrar		Cei	tificate of	Death		Reg. No. 2	18 U/65/
3	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Ye	3. Time of Death
de la como	/Medic		ELIZABETH JOSEP		AUGH	4h Cihi Taum o	r Looption of Doo	FEBRUAL	4c. County of	08 8:12A
	Examin	er	4a. Facility Name (If not institution, give s		:	4b. City, Town, o		τn		
			FREDERICK MEMORIA 5. Social Security Number 6. Sex		rs. la <i>st birthd</i> ay)	FREDERI If Under 1 Year		8. Date of Bir	FREDERI	. Birthplace (State or Foreign
	Funeral Director			N 005	87 Yrs.	Months Days	Hours Min	(Month, Da	6, 1920	Country) \ Maryland
	-	ŀ	Usual Residence of Decedent	21	07		L	11.0 1 1	,	
	yland Iow at	Ì	10a. State 10b. County	10c. 6	City, Town or Lo	cation				10d. Inside City Limits
	Mar a-f sh ffied	혅	Maryland Frederick	c	Thurmon	t				1 ☐ Yes 2X No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th wi		13708 Hillside Ave	enue		2178			U.S	
	ems erm	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin? (: an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		American Indian, White, etc.
9	afte or It		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1□Yes ¾ □No	Specify:		Specify:	Uhito
ğ	hours ural'	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Decer	lent's Usual Occup	nation		16b. Kind of Busin	White mess/industry
ည်	"nat	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Give	kind of work done OO NOT use retired	during most of wo	orking		· · · · · · · · · · · · · · · · · · ·
2	withi ene. than he M	E I	Elementary/Secondary (0-12)	College (1-4or 5+)	Но	nemaker			Own He	ome
2	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden Surname)	
<u>a</u>	ld be ental ked (ic ev	To B	Sidney Byard				Alice 1	Miller		
ar∖	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	_	19a. Informant's Name/Relationship (Typ	pe. Print)					er, City or Town, Sta	
Ž	D = C =		Don L. Clabaugh /						nt, Maryl	
S.	es 1 a of He fiterr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	 Place of Dispo cemetery, crei 	sition (Name of natory or other pla		Date	20c. Location - Cit	
Ĕ	Pages ment of ant; If its ury or o		4 □ Donation 5 □ Other (Specify)	B1		e Cemeter			Thurmont,	
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Luheral Service Livins.	0000	RO.	2. Name and Addre BERT E • I	SS of Facility ALLEY &	SON, FUN	ERAL HOME	S, P.A.
	로디드 등 이		Tolor D	Beller 17	61.	5 EAST MA	IN STREI	ET, THUR	MONT, MD	21788 Approximate
н			23a. Part1. Enter the disease, or complications, or heart failure. List only on				ng, such as cardi	ac or respiratory a	irrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Puimont		3RUSIS				
	/Medical Examiner		1	PHEUM AT		ARTHE	TTTE			
		er	Sequentially list conditions, if any, leading to immediate	Lue to (or as a cons		11/211/44	- 10-3			
	uted f ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o î	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
8760	ate be executed oblysician and the burial-transit	dical	d	l						
9	ertifica ing ph	Med	IF FEMALE:		-					8 1/
စ္က	leath certific attending p I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pred 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnanc	у		23d. Date of Month	
0	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5L	Other (specify) _				
<u>ď</u>	that the ed by detac		Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
Division or Vital Records, P.O. Box	w requires that the de been signed by the s should be detached	d by	SEPSIS					10	Yes 2 No 3	Probably 4 Unknown
S	w req beer shou	Completed	ATRIAL FIB	RTILATION				24a. Was	an 24b. We	re autopsy findings available
æ	nysician: The law nis certificate has b I director, page 2 s	m d	71-1-0-1-0	, , , , , , , , , , , , , , , , , , , ,				- auto perf 1□ Yes	ormed?_ dea	or to completion of cause of ath?]Yes 2 ☐ No
<u>ra</u>	un: T ifficat or, pa		25. Was case referred to medical				26. Place of De	eath Check onl		Tres ZINO
5	ysicia s cer direct	o Be	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	ner: 4 \(\text{Nursing}	Home 5 ☐ Res	idence 6 ☐Other	(Specify)
ō	g Phy ier thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Inju Wo	ry at rk?	28d. Describe	how injury occurred	
Ö	ath. or: Aff	atio	1 ☑ Natural 5 ☐ Pending investigation			M 1□	Yes 2 □ No			
<u>S</u>	for Attending latter death. Director; After in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office			(Street and Number wn, State)	or Rural Route Number,
	oital o urs afi ral D			1-1		h conversed at the t	imo data and ala	and due to the	causa/s) and mann	per as stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my liner: On the basis of exam and manner stated.	nination and/or ir	vestigation, in my	opinion, death oc	curred at the time	, date and place, an	d due to the cause(s)
	o the	Med	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Month, Day, Year)
	F S F Ö		Directino			D	00634	198	2/25	108
•	3		30. Name and address of person who co			Print)				
			Cilicit	ADHWA, M	D 400	West 7th	Street,	Frederi	ck, Maryla	and 21701
1	Sta		31. Date filed (Month, Day, Year) FEB 2 7 2	32. Repistrar's Signature	gnature	Jack !				
	Registi	ell	1 20 7 1	The same of the sa	-	7				

State of Maryland / Department of Health and Mental Hygiene 🔈 🕦 🧌 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Juan Louise Cornelison 4:15 P M Febuary 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 3, 1936 Director 71 June Pennsylvania 191-28-1109 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Point of Rocks Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1602 Gibbons Road 21777 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23s by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Awards Coordinator other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sebastian DeGregorio Kathryn Curley 2 of Health and Nitem 27 Is mai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold R. Cornelison / 1602 Gibbons Rd./ Point of Rocks, MD Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/27/2008 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has page 2 autopsy performed certificate 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 thpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury ours after death.
neral Director: A
filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined within 24 hours at To the Funeral D completely filled i Hospital 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number

7) 0052950 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 LaMont C. Smith, MD / 400 West 7th St. / Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

08-015	62

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Zachary Andrew (man - For State	St	ate of Ma	aryland /	Depart	ment of <i>ficate of</i>	Health Death	n and M	ental H		g. No.	201	00 0100
	R	egistrar I. Decedent's Name	/Eiret Midd	le t ast)		007111	70010 01			-	2. Date of Death	1	Year	3. Time of Death
Physicia Medical Examin		Zachary			าลก						Month February 2			1533 hrs
WEUICAI EXAMINI	-	a. Facility Name (i	f not institution	on, give street				4b. City, To	own, or Locat	ion of Death	1		unty of Death erick	1
		8013 Lighth			17 Ans	e (In yrs. last	birthday)	If Under		Under 24Hrs	s. 8. Date of Birt	h(MM/DD/	(YYY) g. Bir	thplace (State or
Funeral Director	- 1	5. Social Security N 217-96-47		6. Sex		27	Yrs	Months		lours Mir		y 19,	1981 ^{Co}	oun <mark>Maryland</mark>
	_ <u>_</u>	Usual Residence o				10c. City, To	own or Local	tion						10d. Inside City Limits
ow any	- 1	10a. State Maryland	10b. County	erick			derick							1 Yes 2 No
ryland a-f sh	g	10e. Street and Nu						10f. Zip	Code		1	0g. Citizen	of What Cou	untry?
he Mar or 28	Director	8013 Lig	ghthou	se Land	ling			217				USA		dian Plank
with the ms 23a	ral	11. Marital Status			Vas Decedent		. 13. W	as Deceder Yes, specify	nt of Hispani y Cuban, M e	c Origin? (s xican, Puert	Specify Yes or No to Rican, etc.))- 14. 	Race - Ame White, etc.	rican Indian, Black,
death or iter	Funeral	1XX Never Marr		viairieu 1	Yes 2	X No	1	Ves 2	K No sp	ecify:		Sp	ecify: V	V hite
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2 hour	Completed	Elementary/Sec			ollege (1-4 or	5+)			king life. DO	NO1 use re	etirea)	1	A 5	
36 thin 7 re. than	ng l	11					Invent	tory	Clerk	N	ne (First, Middle,		Automo	otive
5-0(led wi Hygier other	S	17. Father's Name Robert	(First, Midd	le, Last)							Collins		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	19a. Informant's N			rint)		19b. Maili	ing Address	S (Street an	id Number o	r Rural Route Nu	mber, City	or Town, Sta	ate, Zip Code) 21701
MD 2 the 2 shoul alth and M m 27 is m aumatic	<u>٢</u>	Cheryl			nother		8013	3 Lig	hthous	e Lan	ding, Fr	ederi	ck, Ma	aryland or Town, State
e, N and 2 Realth item 2	181	20a. Method of D	isposition] c	rematory or	other place	me of cemete)		Date			
nor ages of ant of other		1 X Burial 2			emoval from S	Res	thave	n Memo	orial		27-2008			, Maryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21. Ignature of	uneral Servi	Licensee	1 4	- 1.			Address of		Stauffe Pike, Fr			
	1	Maron 23a. Part I. Enter	va	amul	e 4	d the death	Do not ente	oz I U	of dvina, su	ch as cardia	c or respiratory a	rrest, shock	, or heart	Approximate Interva
Physician /Medical		23a. Part I. Enter failure. List	the disease, only one cau	ise on each iin	e.									Between Onset and Death
aminer	W D	Immediate Cause or condition resu			cotic In									5.14. E. E.
		Sequentially list		b										
	ner	if any, leading to cause. Enter Ur	immediate		o (or as a cor	sequence of	f):							
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and correct name? Schould be detached for use as the burial - transit	a E	75		d	23	D+ T	r 27 29	8a-f n	or ME. of	377 3/2	6/08 amh			
D, be ext sician	edical		ED 									23d	. Date of deli	
Division of Vital Records, P.O. Box 68760 rat or Attending Physician: The law requires that the death certificate I as after death. In a libracion: A fleet this certificate has been signed by the attending physicals in the finance of the strength of should be deathed for use as the bind in the finance of the strength of the strengt	Physician/Me	IF FEMALE: 23b. Was deceded	ent pregnant		3c. If yes, outo		2	Fetal deat	h 3	Ectopic pre	egnancy		Month	Day Year
X 68 th cert ttendir r use a	icia	past 12 mor		Unknown a		at time of de	eath 5	Other (Sp.	pecify)					
Bo he dea y the a	ا م	Part II. Other si		9			esulting in t	he underlyi	ng cause giv	en in Part I.	- 4			e to the cause of death?
P.O.	2	Alcoho		Ocaine U							_ 1_	Yes 2	STATE OF THE PARTY OF	Probably 4 Unknow
ds, l equires	Completed	THEORE	or care	ZOGIJAO C							24a. W au	as an itopsy	prio	re autopsy findings availa r to completion of cause o
COF	1											erformed? es 2 N	dea¹ o 1 ✓	th? Yes 2 No
Re I: The	ع ا		eferred to me	edical							neck only one)		F=3	
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of \ing Phy	F .		Death		28a. Date of (Month, D	Injury ay,Year)	28b. Time		28c. Injury				ny occurred	
ion tendir eath.		1 Natural 2 Accider		Pending Investigation	Found 2	/23/08		3:00pm		es 2 XX N		n on (Street a	and Number	or Rural Route Number, C
Division of Vital Final or Attending Physician: ours after death.	Thied in by me tune	3 Suicide	6 X	Could not be	28e. Place		home, farm,	street, fact	ory, office bu	iligilig, etc.	or Tov Freder	n, State)	013 T.io	hthouse Landing
.E 8 5 6	Dall C	4 Homici 29a. Certifier	de	determined	(Specify)HO		dae daath (occurred at	the time, dat	te and place	and due to the	cause(s) ar	nd manner as	s stated.
Di To the Hospital within 24 hours To the Funeral	completely	(Check only 1 one)	✓ Medica	Examiner:Or	the basis of	examination	and/or inves	stigation, in	my opinion,	death occu	rred at the time,	date and pla	ace, and due	e to the cause(s)
To t with To t	completel	29b. Signature		an	d manner sta	ed			29c. License	number		29d.	Date signed	(Month, Day, Year)
			Morate	_ ()	. Uhul	l			O.C.N	۸.E.		Feb	oruary 24	, 2008
		30. Name and		erson who con	npleted cause	of death (Ite	em 23a)			10	MD 04004			
			a Korell N		stant Medi	cal Exam	iner 11	11 Penn	Street, Ba	altimore,	MD 21201			
	Sta		Month, Day,	^{Year)} 200		istrar's Signa	ature	Same						
Reg			LED	N LUL	1		ORIG	INIAI	, «			0	CME	
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			For State Registrar		State of	Marylan	d / Depa <i>Cei</i>	artment <i>rtificate</i>	of He	ealth a Death	ınd Me		giene Reg. No	2008	076	60
		13	Decedent's Name (Fire	rst, Middle, La	st)				<u> </u>	Outin	2	. Date of De		•	3. Time of De	eath
ľ	Physici		Nellie V	V. Co	stantin	5						Month Februa	ry 2	Year 24, 2008	10:00	a ^M
	/Medic Examir		4a. Facility Name (If not	institution, giv	e street and num	ber)		4b. City, To	own, or t	ocation o				County of Deat		
	<u> </u>	Ē	3913 Queer	Mary	Drive	7 Ama (In	la a A fair-Ab -da- A	O1 If Under 1	ey.	If Under 2	14 Hro 1 o	Data - (Bist		Monto	omery	
1	Funeral Director	1	5. Social Security Number 579-24-309	1	M 2.3 F	7. Age (In yrs. I 84	Ven		Days	Hours	Min.	. Date of Birt (Month, Da	y, Year)	Co	nplace (State or F untry)	oreign
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	yland now		10a. State 10b	. County		10c. City	, Town or Lo	cation				_			10d. Inside City I	Limits
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	with the Maryland a or 28a-f show t be notified at	Director	Maryland Number	1011 tgon	iery		Olney	10f. Zip C	ode				10g. Cit	izen of What Co	untry?	
	ath w		3913 Que	en Mary						832				USA		
21215-0036	within 72 hours after death with the Maryland liene. I than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Da	ces? 2⊠No e		Was Decede f Yes, specif l □ Yes 2		panic Orig , Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, White Specify: W		
2-0	72 ho natur lical I	Completed	15. (Specify of	Decedent's Ed	lucation ide completed)			tent's Usual kind of work			of working		16b. K	ind of Business/	Industry	
21	within and the series.	ם	Elementary/Secondary		College (1-	4or 5+)	life.	DO NOT use	retired)	uung most	or working					
21	filed wi Hygier other th		12				Home	maker						Home		
gue	be fill Hall Hedouth even	Be	17. Father's Name (First	. ,								First, Middle,		,		
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Maryland	d 2 sl th an 7 Is r traur		19a. Informant's Name/I			ısband	19b. Maiir	-						n Town, State, 2 .ney, MD	. ,	
	s 1 and 2 should f Health and Mer ttem 27 Is marke other traumatic	1.0	20a. Method of Disposition	on		20b. P	lace of Dispo	sition (Name	of		Dat			ocation - City or		
Baltimore,			1y☐ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐			tate	emetery, cier t Linc			i F	Feb.	28,	D			
alti	permit. Page Department of Important: If any injury of once.	1	21. Signature of Funera			1.02		. Name and			2008	5	brer	twood,	Maryland	_
ä	an jan) (in	.lew	Sta	le	F	rancis 00 Uni	J.	Coll sity	lins l Blvd	Funera	l Ho Silv	me Inc.	ng, MD 2	0901
I			23a. Part1. Enter the dis shock, or heart fail	sease, or com	plications that ca	used the death									Approximate Interval Between	en
ě	Physician	î î	Immediate Cause (Final disease or condition		- 200	iratory									Onset and Dea	ath
4	/Medical		resulting in death)		- C.	r as a consequ									I WCCK	
慑	Examiner	_	Sequentially list condition	ons,		nic Obs		ve Pul	mon	ary [)isea:	se		9	10 Years	
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	late 2	Due to (o	r as a consequ	isnoa of):									
16	xecut and al-tran	xan	that initiated events resulting in death) Last		c	r as a consequ	uence of):									
8760,	cate be executed oblysician and the burial-transit	dical E		·		•	ŕ									
687	ficate physics the	edic			o											-
.O. Box	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	ths?		th 2 ☐ Fetal int at time of de	death 3	Ectopic prec Other (spec		-				23d. Date of del Month	ivery Day Yea	ar
Δ.	that the de led by the a detached i		Part II. Other significant	t conditions	ontributing to dea	ath but not resu	ılting in the u	nderlying cau	se giver	in Part I.		23e. Did to	obacco i	se contribute to	the cause of dear	th?
Records,	igi be	d by	cancer of 1	ung								1 🗆 🖈	es 2	□ No 3□ Pr	obably 4 □Unk	nown
CO	s been s should	Completed										24a. Was	an	24b. Were au	topsy findings ava	ailable
Re	The law rate has b	mo											rmed?	prior to death?	completion of caus	se of
or Vital		Be C	25. Was case referred to	o medical						26. Place	of Death	1⊡ Yes Check onloo	2 □ x No ne	1 □Yes	2□No	_
\ \ \	Physician: r this certific ral director,	To E	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 ☐ In	patient 2 □ I	ER/Outpatien	t 3□ DOA	Other	: 4 □ Nur	rsing Home	5 TeResio	lence	6 □Other (Spe	cify)	
n 0	ng Pt		27. Manner of Death 1 Natural 5 [☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	280	. Injury Work?	at	28	d. Describe h	ow inju	y occurred		
Sio	Attending r death. ector; After by the fune	atic	2 Accident	investigation Could not be	1			M		es 2 🗆 N	10					
Division	or Att	Certification:	3 Suicide 6 [4 Homicide	determined	28e. Place	of injury - At ho g, etc. <i>(Specif</i> y	me, farm, str	eet, factory,	office		28	f. Location (S City or Tou	Street an n, State	d Number or Ru e)	ıral Route Numbe	r,
	pital ours a eral [29a. Certifier	Certifuing Ph	ysician: To the b	aget of my know	ulodgo dootl	occurred at	the time	n data an	d place on	d due to the	2012000	and manner of	atatad	
	the Hospital nin 24 hours a the Funeral I npletely filled	Medical			niner: On the bas	sis of examinat										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title	of certifier	1 =	0_1		29c. I	icense	number			29d. Da	te signed (Mont	h, Day, Year)	
	۱۸		Tome	se sh	Vernen	10/1	na			d121	.21			Februar	y 25, 20	80
	(0		30. Name and address of George Sen	of person who	completed cause	of death (Item 929 Fe:	23a) (Type, rrara	Print) Drive,	Wh	eaton	, MD	20906				
4	Sta	te	31. Date filed (Month, Da	ay, Year)												
	Registr			2 6 200	18	gistrar's Signat	A SE	W.		_						

			1 - For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artmer rtifica:	nt of H	lealth a Death	and M		jiene leg. No.	200	8 07	661
F.	16		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	ith Day	Year	3. Time o	f Death
*	Physici /Medi		Floyd I	f. Cesle	r						February		200	0.1	5 a ^M
	Examir		4a. Facility Name (If not institution, give	street and numbe	er)		4b. City	Town, o	r Location of	of Death		4c.	County of De	ath	
	Latini		44 Landsend Dri	ve				Ga	ithers	burg			M	lontgomery	
	Funeral		5. Social Security Number 6. S		Age (In yrs. la	ast birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day	Voor	9. B	irthplace (State	or Foreign
	Director		230-76-5827	⊠ M 2□F	54	Yrs.	Months	Days	Hours	Min.	August 2			Country) Virginia	
5.4	d major me differ		Usual Residence of Decedent												
	ow at		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside C	City Limits
	Man f sh	to	Maryland Montgo	merv				Gaith	ersbur	2				1 XIYes	2 □ No
	the 28a	rec	10e. Street and Number				10f. Zi	o Code		0		10g. Citi	zen of What (Country?	
	with a or	Ö	44 Landsend Dri					2	20878				U.S	. Δ	
	eath	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S	3 13	Was Dece			iain? (Spe	ecify Yes or No-			nerican Indian,	
	item ner	Ë	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2	s?		If Yes, spe	ecify Cuba	an, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)		Black, Wh	nite, etc.	
36	s aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 🗆 Yes	2 X No	Specify:	:			Specify:	White	
21215-0036	hour tural	Š T	15. Decedent's Ed			16a. Dece	dent's Usi	ial Occur	ation			16h Ki	nd of Busines		
<u> </u>	"na "na edic	Completed	(Specify only highest gra			(Give		ork done	durina mos	st of worki	ing			,	
12	withii ene. than	Ę	Elementary/Secondary (0-12)	College (1-4c	or 5+)				- chnici	an			Rese	earch	
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at		12 17. Father's Name (First, Middle, Last)	-		Бо	D MILL	101 IC			e (First, Middle,	Maiden			
ŭ	be f d oil	Be									n Johnson				
ΣĮξ	ould Mer narke	ဥ	Gordon Cesler										- O	77. 0	
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Type. Print)				,			al Route Numbe				
2	and ealth n 27 ner tu		Dana L. Cesler - W	Lfe					ve, Ga		sburg, Ma				
ore	of H fiter		20a. Method of Disposition 1 Burial 2 Cremation 3	Remova from sta	CO	ace of Dispo emetery, cre	osition (Na matory or	me of other plac	ce)	L	Date	20c. Lo	cation - City	or Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specif			on Ceme	etery			02/2	26/2008	Burt	onsvill	e, Maryla	nd
alti	permit. Departr Importa any inju		21. Signature of Funeral Service Licer	isee					ss of Facili		Inna Tan				
m	o a m		Harry	MIX	mi	1	1800 l	Kinaic New Ha	n rune Impshir	re Ave	lome, Inc.	er S	pring, M	laryland 2	20904
			23a. Part1. Enter the disease, or com shock, or heart failure. Vist only	plications that caus	sed the death	. Do not en	ter the mo	de of dyir	ng, such as	s cardiac o	or respiratory ar	rest,		Approxima Interval Be	ate
	Physician		Immediate Cause (Final											Onset and	Death
<u> </u>	/Medical		disease or condition resulting in death)	u	piratory as a consequ		re							2 year	rs
	Examiner				gestive		in lur							3 year	rs
н		<u>-</u>	Sequentially list conditions,	b	as a consequ		aridi							7 7522	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·											
	and and II-tra	xar	that initiated events resulting in death) Last	c Due to (or	as a consequ	ence of):									
8760,	be e ician buris	a E													
87	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		d	<u> </u>										
9 ×	death certific attending p	/Me	IF FEMALE:	23c. If yes, outcor	mo of pregnar	ncv							00.1 5.1	1-12	
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	n 2 □ Fetal	death 3	Ectopic		у				23d. Date of of Month	Day	Year
	ne de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9∐Unknowr	t at time of de n	eath 5	Other (s	ресіту) _						ľ	
P.0	that the ded by the detached	Physician/Me			L I	dain no inc Ale no o			on in Dark		220 Did to	ahaaaa 1	ino contributo	to the cause of	doath?
	signed be det	by	Part II. Other significant conditions		n pul nol resu	illing in the c	indenying	cause giv	en in Fart	1.					
ord	w requir been si should	ed	End Stage Renal D	isease					_		'''	/es 2	<u>M</u> (40 3 □	Probably 4	JOHNIOWII
ပ္ထ	≥ Q IS	Completed									24a. Was autop		24b. Were	autopsy findings to completion of	s available
Ä	The lavate has	mo									perfo	rmed? 2 🗷 No	death	? es 2 □ No	04400
tal	an: tifica or, p		25. Was case referred to medical						26. Place	e of Deat	h (Check only o				
or Vital Records,	Physician: The la this certificate has ral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inp	atient 2 □ 8	ER/Outpatie	nt 3□ D	OA Oth	201:	-	ome 5 A Resid		6 □Other /S	pecify)	
Ö	Phy or this eral o		27. Manner of Death	28a. Date of I	njury	28b. Time o		28c. Inju			28d. Describe h			p c c , ,	
on	ding Phy h. After this funeral o	tion	1 x Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м		rk? ∣Yes 2.⊟]No					
S	Attending r death. ector: After by the funer	ica	3 Suicide 6 Could not b		iniury - At hor	me, farm, st	reet, facto	rv. office			28f. Location (S	Street an	nd Number or	Rural Route Nui	mber.
Division	lor A after Direction by	Certification:	4 ☐ Homicide determined	building	, etc. (Specify)	,	,			City or Tov	vn, State	9)		,
_	pital ours eral filled		29a. Certifier 1 X Certifying Pt	ysician: To the be	est of my know	wledge dea	th occurre	d at the ti	ime date a	and place	and due to the	cause(s) and manner	as stated	
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the i	Medical		niner: On the basi	s of examinat										(s)
	To the within 2	Mec	29b. Signature and fittle of certifier	and mariner	Stateu.		25	9c. Licens	se number			29d. Da	te signed (Mo	onth, Day, Year)	
	7. ≥ 7 8		I I MA				-								
	4		1/mv0.00					D2	1340			re	or dary	25, 2008	
	1		30. Name and address of person who												
			Raymond A. Bass,				, Whea	ton,	Maryla	nd 20	0906				
	St: Regist	ate	31. Date filed (Month, Day, Year)	108 Janes	istrar's Signat	ture	acht.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Brenda, 10:45AM Conner Jean 26 Feb. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

JAN. 25, 1952 **Funeral** Birthplace (State or Foreign
Country) Hours Months Days 1 □ M 2 1 1 F Director 219-60-2557 56 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show sa or 28a-f show t be notified at 1 ☐ Yes 2 X No Director MARYLAND WASHINGTON **FAIRPLAY** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a caminer must be 17343 SPIELMAN ROAD 21733 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 ☐ Divorced Year or Dates: WHITE "natural", Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta I Item 27 is marked r other traumatic e JOSEPH ALVIN KEEFER SR. ROSE MARIE GREENWALT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 195, KEEDYSVILLE, MARYLAND JUDY R. BURNHAM/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If Its any injury or o once. 1 ☐ Buria! 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spec STAUFFER CREMATORY, 2/29/2008 | FREDERICK, MARYLAND 21. Signature of E 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 3 days /Medical Due to (or as a consequence of): Examiner Cirrhosis 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit the death certificate be executed Cholongiocoranoma 3 weeks Due to (or as a consequence of) physician a Box 68760, Physician/Medical as signed by the attending | d be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş Chronic renal insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed mellitus type II 24b. Were autopsy findings available prior to completion of cause of autopsy death? perform 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Smith 31. Date filed (Month 2008

(Check only one)

29b. Signature and title of certifier

Catherine

22 South Greene Street, Baltimore, MD 21201 strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

1386847903

29d. Date signed (Month. Dav. Year)

Feb. 26 2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Feb 27, 2008 4:16 a Clopper **Physician** Thomas Pearre /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Williamsport 4c. County of Death **Examiner** Washington 16505 Virginia Ave 8. Date of Birth (Month, Day, Year) Sept 5 1917 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ₹M 2 □ F Months Days Hours 90 216-01-3071 Sept Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location
Williamsport 10d. Inside City Limits 10b. County Washington s 23a or 28a-f shoust be notified a MD 1 ☐ Yes 2√2 No Director 10f. Zip Code 21 795 10e. Street and Number 16505 Virginia Ave 10g. Citizen of What Country? 'natural', or items 23a or dical Examiner must be U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any filury or other traumatic event, the Medical Examine 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: sowhite þ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) electric Elementary/Secondary (0-12) College (1-4or 5+) accountant company 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Mae Eichelberger Thomas Franklin Clopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12427 Nesbitt Ave Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type. Print) wife Thelma Clopper 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Cemetery 2008 20c. Location - City or Town, State 20a. Method of Disposition March 1, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, 21. Signature of Funeral Service Licen P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death 23a. Patt. Enter the disease, or complications that caused the death. Do not enter sheck, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician mouca resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): be exec P.O. Box 68760 Physician/Medical as If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? perforr 1 ☐ Yes 2 ☐ No il or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA William Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending 1 Tes 2 No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framiner: On the basic of exemination and/or immedication in the cause of exemination and or immedication. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a

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ompleted cause of death (Item

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 18,2008 1:48 pM Chisley Raymond /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 07/25/1950 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F 57 213-56-0651 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director District Heights Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 20747 USA 2102 County Road Apt. 202 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗓 No 3altimore, Maryland 21215-0036 Specify. }q 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4or 5+) Elementary/Secondary (0-12) United Investor 12 Maintenance Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Lancaster Chisley Mary Ethel Raymond ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 138 42nd St. N.E. Washington DC 20019 Keasha Chisley/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/26/08 Clinton, Maryland Resurrection 21. Sign ture of uneral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CI-dimo **Physician** PIT HASIM /Medical Due to for s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the aftending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? sign**e**d l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 □ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 2□No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 □ No funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann of Death 1 Matural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours at To the Funeral C l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Rd. Clinton mD ERIC MCDONAID MD 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State FEB 2 6 2000

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CASARELLO Month **Physician** SAMUEL 02 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mandrin Chesapeake Hospice House Harwood Anne Arundel 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 85 12/4/1922 Director 198-14-2652 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modcal Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 930 Astern Way, #106 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ճ Yes 2 □ No If Yes, Give Year or Dates: W.W. II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White ş Specify: 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Contractor Plumbing s 1 and 2 should be filed v if Health and Mental Hygie item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Casarella Anna Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Casarella/ Son 714 Crisfield Way, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ■Burial 2 □ Cremation 3 □ Removal from State 2-26-08 Mt. Olivet Cemetery 4 Donation 5 Other (Specify) Carverton, PA 21. Signatur Fun Jule Compensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** eun disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 25 No 3 Probably 4 Unknown 1 🗌 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 241No page 2 certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Souther (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA After this c funeral din ٩ 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: +0450 1 Natural
2 Accident 5 ☐ Pending Within 24 hours after vec......
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** РМ 3 2250 Beatrice Jane Carroll March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 Laurelwood Care Center E1kton ELKCO11

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

| Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs NOV 4. Director Pennsylvania 217-12-9533 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County or 28e-f show trsumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Fawn Grove Pennsylvania York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural, or items 23a
eny injury or other traumatic event, tra Medic 883 Bridgeton Road 17321 United States by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Teller/ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Banking Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Foote Mary Mackie 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 883 Bridgeton Road, Fawn Grove, PA 17321 Lawrence H. Carroll, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 7, Sharps Cemetery 2008 Fair Hill, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21921 21. Signa ure of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE COPD **Physician** END /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if the latent cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consumence of : Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760, attending physicien Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy be detached for Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANEMIA 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? CHF has autopsy performed certificate 20 No 1 ☐ Yes 1 Tyes CAD erel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ Mo Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injuy (Month, vay Ye. r) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Playe of Injury At home, farm, street, factory, office building, etc. (pecify) 4 Homicide within 24 hours a
To the Funerel (
completely filled To the Hospitel Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05MAR08 DS4073 Hom buted cau e of death (Item 23a) (Type, Print) 30. Name and address of person who do

Registrar

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

CINRIHMANS COR HELGISTUT DE 19720

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) February 22, 2008 Physician 1:30 P M Ernest Joseph Delia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert County 295 Chesapeake Avenue or Foreign 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**∑**M 2□F 26. 1919 Ohio Sept. Director 297-05-2084 22 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Prince Frederick Calvert County 10g. Citizen of What Country? 10e. Street and Number 295 Chesapeake Avenue 20678 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Investigator State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Mariol ပ္ Joseph Delia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11533 Timberbrook Drive Waldorf, MD 20601
ce of Disposition (Name of Disposition - City or Town, State <u> Michael Delia (Son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 1 Burial 2 □ Cremation 3 □ Removal from State John Vianney Cem 28, 2008 Prince Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funda 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition month **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After t (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number title of cortile 29b. Signature an 08

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30. Name and adress of per

31. Date filed (Month, Day, Year)

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of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:05 A M JUNE ROSE DUCHARME FEB 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 13, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Days Months Hours 1 □ M 2 □ xf 204-12-6231 83 June 1924 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Directo Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 Jasmine Terrace 20783 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No White Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie
Important: If Item 27 is marked other ti
any injury or other traumatic event, the Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Loughney Loretta Maghran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. DuCharme/Husband 1802 Jasmine Terrace, Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. Date 27. 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funera 21. Signature Service Licen: 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 ➡Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01062935A (IN)

DHMH 17 Rev 1/200

State

Registrar

CENTER

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LT

MC

USN

Registrar's Signature

AMANDA R. SEI
31. Date filed (Month, Day, Year)

SELF

2 6 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day
February 23, **Physician** 2008 9:50 Peter G. Demaris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 5802 Nicholson Lane, #2-308 Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 1 X M 2 □ F 73 4, 194-26-7399 Sept. 1934 Greece Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5802 Nicholson Lane, #2-308 20852 USA Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify 3 DWidowed 4 Divorced "natural". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Private of Health and Mental Hygie fitem 27 is marked other t r other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Demaris Efterpi Steliotis Demaris Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #2-308
5802 Nicholson Lane, Rockville, MD 20852 19a. Informant's Name/Relationship (Type. Print) Patricia Demaris/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or otl 25. Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 22, Name and Address of Facilit 21. Signatur o Funeral Service License Francis J. Collins Funeral Home Inc. W., Silver Spring, MD 20901 500 University Blvd. 23a. Part1. Enter the disease, or com shock, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed sician and burial-trans Valvular Heart Disease Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' certificate ! 1□ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After **Hospital or Attending** 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29d, Date signed (Month, Day, Year) 29b. Signature and the of ce 29c. License number D40948 February 25, 2008 10 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 2101 Medical Park Drive, #301, Silver Spring, MD 20902 Julie Fox, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature 26 FEB Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #20b, 2-26-08, per FHDR CHICATO Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Priscilla John Eacock Dunenfeld 21, 10:49 AM February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 16912 Glen Oak Run Derwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2X F 372-24-4592 81 1926 Michigan Director July 17, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at show 1 XYes 2 No Director Willis Texas Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a 77318 USA 12685 Antares Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>ک</u> Specify: 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 5+ Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flora Rose Bigelow John Smiley Eacock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Dunenfeld Black/daughter | 16912 Glen Oak Run Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2-22568 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) $\frac{02/2/08}{}$ Chesapeake Crematory Beltsville, MD 21. Signature of Funeral-Service Licent 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Deve Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) a Sepsis /Medical Due to (or as a consequence of): **Examiner** b. Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy 1 Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) NOME Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 21, 2008 D64615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) FEB 2 6 2008 DHMH 17 Rev 1/2001

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Elizabeth Vec 03 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battimore Inworalty mory land of 8. Date of Birth (Month, Day, Year)
Auq • 17, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗆 🕦 Yrs. 80 1927 Canada Director 031-28-1893 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1XIYes 2□No Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 USA 419 Paradise Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes **2** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: white <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accounting <u>Administrative assistant</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Ferguson Olive Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21001 419 Paradise Rd., Aberdeen, Thomas Dee (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 3/7/2008 4 □ Donation 5 Other (Specify) West Chester, PA R.A. Ferris & Co. 21. Signature 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. nd 21001-3399 Aberdeen, Maryland 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) me to bolic 90,00515 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Vear in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 1XYes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: J⊒res 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 0 TSICIO 0060292 08

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Boltimore MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jay Menator

31. Date filed (Month, Day, Year)

S. Greane

32. Registrar's Signature

DI

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** Month Margaret Ellen Ellison February 22. 2008 2:12 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2025 Oliver Drive Prince Frederick Calvert County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Yrs. Director 88 212-16-5647 7, 1919 Virginia April Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2X No Director MD Calvert County Prince Frederick 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 2025 Oliver Drive 20678 U.S.A. Funeral . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Manufacture Elementary/Secondary (0-12) College (1-4or 5+) Wireman Aviation Parts permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygir Important: If item 27 Is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lee Howard Spencer Josie Blanche Owen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2025 Oliver Drive, Prince Frederick, MD 20678 ace of Disposition (Name of Local Date 20c. Location - City or Town, State Joyce Savelli (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Cem. 29, 2008 Annapolis, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funda 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12heimen Immediate Cause (Final Physician LYK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eveloral vascul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 4☐Pregnant at time of death 5 Other (specify) Ö the 9□Unknown 9 ☐ Unknown signed by t d be detach Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has e 2 certificate has irector, page 2 autopsy perform director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my policies, death

Division or Vital Records, or Attending Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10845 Town Center Blvd. #203. Dunkirk, MD 20754

and manner stated.

Catherine I. Brophy, M.D. 31. Date filed (Month, Day, Year)

FEB 2 6 2008

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

Physician
/Medical
Examiner

Funeral Director

and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. show r 28a-f sh notified o pe permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760 Hospital or Attending F 24 hours after death. Funeral Director: After To the Hospital within 24 hours at To the Funeral D (0)a2-

1. Decedent's Name (First, Middle, Last) 2. Date of Death February 23, 2008 Englander 11:05 A M Ruth Sunshine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Collington Mitchellville Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 19, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F New York 072-12-4377 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 10450 Lottsford Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify:White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ombudsman University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Sunshine Sally Lehr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8817 Endless Ocean Way Columbia, MD 21045 Judith L. Burt/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 02/26/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of Funeran Service Licensee Going Home Cremation Service P.O. Box 784 Dever M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction 1 hour Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖁 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Congestive Heart Failure, Aortic Stenosis, Anemia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 2 🗋 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47603 February 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William DuBoyce, M.D. 12158 Central Ave. Mitchellville, MD 20721 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 26 2008 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

FEB 2

32. Registrar's Signature

			For State		State of M	laryland / I		artment of F ctificate of			ental Hy	/gien Reg. N	200	8	07676
	100	-	Registrar Decedent's Name	(First, Middle,	Last)		-	timouto or	Doain		2. Date of D	eath			3. Time of Death
	Physici										Month Febru		20, 20	08	12:20 A ^M
727	/Medio		4a. Facility Name (If		R. Fox give street and number			4b. City, Town, o	r Location of	of Death	Tebra	-	c. County of E		12.20 A
			17309 C1 5. Social Security Nu			ge (In yrs. last bi	rthday)	Upper M	arlbo		8. Date of B	irth	Prince		orge s
	Funeral Director	8 1	579-64-54		1□M 2XF	59	Yrs.	Months Days	Hours	Min.	(Month, D	ay, Yea 194	r)	Countr	y)
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	nylan how at			10b. County		10c. City, Tow								10	d. Inside City Limits
	e Ma a-f s tifled	cto	Maryland	Prince	George's	Upper	Ma	rlboro							1 CXYes 2 No
	ith th or 28 e no	Funeral Director	10e. Street and Num	ber				10f. Zip Code				10g. C	citizen of What	t Countr	y?
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	r deg	nue	11. Marital Status		12. Was Deceden Armed Forces	?	13.	Was Decedent of F f Yes, specify Cub	łispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or N Rican, etc.)	lo-	14. Race - A Black, V		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Fu	1 ☐ Never Marrie 3 ☐ Widowed		d 1 □ Yes 2 🔀 If Yes, Give Year or Dates			1 □ Yes 2XX No	Specify:				Specify:	B1a	ick
215-0036	thour atural	Completed by		15. Decedent's	Education		. Dece	ient's Usual Occup	ation			16b.	Kind of Busine	ess/Indu	ıstry
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212	rould be filed within 1 Mental Hygiene. narked other than natic event, the Me	E	Elementary/Secon 12 year	S	Oollege (1-40)	3+)	Med	ical Ass	istan	t			Privat	te	
pu	al Hy l othe	Be	17. Father's Name (•				18. Mothe	er's Name	(First, Middl	e, Maide	en Surname)		
<u>la</u>	should b ind Ment marked umatic e	2	Euftea	Doughe	rty				Ma	ary R	. McCı	cack	en		
Maryland	2 sho n and is ma		19a. Informant's Nar	me/Relationship	(Type. Print)	198	o. Mailir	ng Address (Street	and Numb	er or Rura	l Route Num	ber, City	or Town, Sta	te, Zip (Code)
	and ealth n 27 ner tr	a a	Anthony D		y - Son			Button B	ush C						
ore	yes the Hitel		20a. Method of Dispo		B □Removal from State	cemete	ery, cirei	sition (Name of natory or other pla			ate		Location - City		
Ë	Pag tment tant: jury o		4 Donation	5 ☐ Other (<i>Spe</i>	ecify)	Fort		coln Cem					Brent		·
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Signature of Fur	neral Service Li	cepece	AIII	22	Name and Address Addres					neral H ington,		•
1			23a. Part Enter th	e disease, or c	omplications that cause nly one cause on each	ed the eath. Do	not ent	er the mode of dyi	ng, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between
	Physician /Medical	Immediate Cause (Final disease or condition Hypertensive Athersclerotic Cardiovascular Disease										≘ '	Onset and Death		
			resulting in death)	4	Due to (or a	s a consequence	of):								
	Examiner		Sequentially list con	ditions,	b										
	pe tis	ine	cause. Enter Under Cause (Disease or in that initiated events	lying	Dua to (or a	в а попвадиелое	017								
_	and i-tran	Examiner	that initiated events resulting in death) La	ast	c	s a consequence	of):								
58760,	icate be executed physician and s the burial-transit	a					/-								
587	ficate phys s the	dical			d										
Box	certii nding Ise a	M/c	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom								23d. Date of	f deliver	v
ğ	death certifi e attending d for use as	ciar	in the past 12 r	months?		2 Fetal deatl at time of death		Ectopic pregnanc Other (specify)	у				Month		Day Year
P.O.	that the death certifii ed by the attending p detached for use as	Physician/Me	9 Unknown	1110	9□Unknown										
	The law requires that the site has been signed by the bage 2 should be detache	y P	Part II. Other signifi	cant condition	s contributing to death	but not resulting i	n the u	nderlying cause giv	en in Part I	1.	23e. Did	l tobacco	o use contribu	te to the	cause of death?
ğ	quire en sig uid b	pe p									1 [] Yes	2 X No 3[] Proba	bly 4 ☐ Unknown
Records,	law re as bee 2 sho	Completed by									24a. Wa		24b. Wer	e autop	sy findings available
Ä	i cian: The lav certificate has ector, page 2	m _o									per	opsy formed? Z□ I	deat		
Vital	ysician: The is certificate hadirector, page	Be C	25. Was case referre	ed to medical					26. Place	e of Death	(Check only				
or V	dir	To E	1 ☐ Yes 2 ☐X	No	Hospital: 1 ☐ Inpa	tient 2 ER/O	utpatier	t 3□ DOA Oth	ner: 4□ Nu	ursing Hon	ne 5 ½ Re	sidence	6 Other (Specify,)
0	ding PI J. After th funeral	E	27. Manner of Death	5 ☐ Pending	28a. Date of In (Month, D		Time o Injury	Wo	ry at rk?	2	28d. Describe	e how in	jury occurred		
Sio	Attending r death. ector: After by the fune	catic	2 Accident	investiga 6 ☐ Could no	the				Yes 2□						
Division	or Attend fter dea h. Director / in by the fi	Certification:	3 ☐ Suicide 4 ☐ Homicide	determin	20e. Place of I	njury - At home, fa etc. <i>(Specify)</i>	arm, str	eet, factory, office		2	28f. Location City or T	(Street own, Sta	and Number o ate)	or Rural	Route Number,
0	pital lurs eral [29a. Certifier	1 X Cortifuing	Physician: To the bes	t of my knowledge	o dob	h conversed at the ti	mo data a	nd place of	and due to th	0.001100	(c) and mann	or on oto	ntod.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical			xaminer: On the basis and manner	of examination a									
	Nithin No th	Me	29b. Signature and t	title of certifier	\cap \bullet			29c. Licens	se number			29d. [Date signed (N	Aonth, E	Day, Year)
			_ ▶ \(\dag{\pmatrix}	Len	ex Hul	∞)	D520)15 MI)		Fel	bruary	25,	2008
.0	(10)	1	30. Name and addre	ess of person w	ho completed cause of	death (Item 23a)	(Type,	Print)	27 E						
1			Atlener A	Artis-T	rower, MD 4	4700 Ber	wyn	House Rd	#101	Col.	lege_P	ark	MD 20	740	
	Sta		31 Date filed (Monti	h Day Year)	32. Regis	trar's Signature	A.	,							
	Registr	ar	FEB 2	7 2008	Blown.	r below	-								

DHMH 17 Rev 1/2001

			1- For State of Maryland / Department / Depa	artment of Health and N rtificate of Death		ene g. No. 2008	07677			
	Physici		Decedent's Name (First, Middle, Last) RODGER LEE FERRELL		2. Date of Death		3. Time of Death 7:30A			
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 19542 FISHER AVE.	4b. City, Town, or Location of Death POOLESVILLE	L	4c. County of Death MONTGON	1			
	Funeral Director		5. Social Security Number 224-60-8770 Usual Residence of Decedent 6. Sex / 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, JAN 3	Day, Year) Country)				
	Maryland I-f show fied at	tor	10a. State		-		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
	3a or 28a	Il Direc	10e. Street and Number 19542 FISHER AVE.	10f. Zip Code 20837	10	Og. Citizen of What Cou	untry?			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Very 2 No 1964		Was Decedent of Hispanic Ongin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)					
21215-0036	d within 72 ho giene. r than "natur the Medical.	Completed	(Specify only highest grade completed) (Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired) STICS ANALYST	ing	GOVERNME	·			
Maryland ?	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) ROBERT E. LEE FERRELL	18. Mother's Name CORA S						
	and 2 sho ealth and n 27 Is m		DAWN RAMOS / DAUGHTER 111	ng Address (Street and Number or Run 4 KESWICK PL.,	FREDER	ICK, MD	21703			
Baltimore,	Pages 1 tment of H tant: If iter		4 Donation 5 Other (Specify)	matory or other place)	27/08	FREDERIC				
Ball	permit Depart Import any In		· W. Pell	2. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BA	RNESVI		20838			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ter the mode of dying, such as cardiac of		Disease	Approximate Interval Between Onset and Death			
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n A	1		10+ YEARS			
8760,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last c							
O. Box 6	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi		⊒Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year			
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
Vital Records,	'slclan: The law re certificate has bee irector, page 2 sho	Completed			topsy prior to completion of cause of death?					
	s certific	Be	25. Was case referred to medical example? 1 □ es 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatien	26. Place of Death		e) nce 6 □Other (Spec				
Division or	To the Hospital or Attending Physician: The within 24 butus after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manne Death 1 Datural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Injury		28d. Describe ho		ury)			
Divis	lospital or Attene I hours after death uneral Director: sly filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet and Number or Ru , State)	ral Route Number,					
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.							
	with To 1	Σ	29b. Signature and title Acertifier Way K	R6072 N	NISSOURI 3	2/25/08	n, Day, Year)			
1	λ		30. Name and address programmed and death (Item 23a) (Type,	Print) NTER Dether	ח מוס	ΛĎ				
	Sta Registr		31. Date filed (Month, Day, Year) See Begistrar's Signature 32. Registrar's Signature	Acade 1	yp L	710				

			For State Registrar	State of M	larylan			nt of H <i>te of L</i>		d Menta		ene g. No. 20	08	07678	
	Physici /Medic		1. Decedent's Name (First, Middle, Las	LOUIS	SE G	UBI:	SC H				te of Death onth		Year 2005	3. Time of Death 0930 M	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City		Location of De	eath		4c. County of	of Death		
				Medical Co		11 t 1 t 1- 1	If Lind	Ann er 1 Year	apolis If Under 24 F	dre la Da	to at Diale	Anne A			
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex □ M 2 F /. A	ge (<i>in yr</i> s	last birthday) Yrs.	Months			lin. (Mo	te of Birth onth, Day,	Year) 1932	Cour	place (State or Foreign ntry) qinia	
			Usual Residence of Decedent							0 0.1		2302			
	ırylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits 1 ☐ Yes 2 No	
	Ba-f s	Director		Arundel		An	napo								
	with the		10e. Street and Number	Young			}	ip Code 21401			10	g. Citizen of W USA	nat Cour	itry?	
	death with the Maryland ms 23a or 28a-f show r must be notifled at	Funeral	928 Shipmaster (12. Was Decedent		.S. 13.				(Specify Ye	es or No-		- Americ	ean Indian,	
30	be filed within 72 hours after death with the Marylan ital Hygiene. dother than "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	MNo			ecify Cuba 2017 No	spanic Origin? n, Mexican, Pu Specify:	uèrto Rićan,	etc.)	1	White,		
3-003p	2 hou latura Ical E	ted	15. Decedent's Education 16a. Decedent's Usual Occupation							1	6b. Kind of Bu	siness/In	dustry		
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and		Be	17. Father's Name (First, Middle, Last) Joseph Henry Gili	^OV						ie Ire			∌ <i>)</i>		
≥	s 1 and 2 should be if Health and Mental Item 27 Is marked o other traumatic ev	2	19a. Informant's Name/Relationship			19h Mailii	na Addre:	ss (Street a				City or Town, S	State Zir.	Code)	
			Lynn M. Patton/Da				-					ersburg		*	
ore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other to		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □		₽	Place of Dispo			- F'6	Date eb. 2	96	Oc. Location -	•		
altimol	artme artme ortani Injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Gat	e of H	2. Name	and Addres	s of Facility	2008	-		~	g, Maryland	
מ	permit Depart import any ir once.			ast		F	ranc	is J.	Collin			Home I		MD_20901	
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liniting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Approximate Interval Between onset and Death	
98700,	certificate be executed ding physician and ise as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last C												
.C. BOX 0	eath atter for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown								23d. Date of delivery Month Day				
as, r	sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I.	23	3e. Did tob 1 □ Ye	acco use contribute to the cause of death?			
tecoras,	The law req ate has beer bage 2 shou	Completed								2	ta. Was an autopsy perform	/ l n	Vere autorior to co	opsy findings available impletion of cause of	
	r: Th licate r, pag		25.11	·							☐ Yes 2	No 1	Yes	2 □ No	
VII	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat	tiont 2	ER/Outpatier	nt 3□[Othe	26. Place of			nce 6 □Othe	on (Connel	4.1	
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5	nding Ith. r: Afte e fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	M		<br Yes 2 □ No						
DIVISION	al or Atteral after dea	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 — ertifying Ph (Check only one) 2 — Medical Exam	ysician: To the bes niner: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurre vestigati	ed at the tin on, in my o	ne, date and p pinion, death o	lace, and du occurred at t	ue to the ca the time, da	ause(s) and ma ate and place, a	nner as s and due t	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1 24		7.4 1.4 .	- 1	9c. License	C 19	10-		d. Date signed		-	
	15		30. Name and address of person what	pleted cause of	death (Item	n 23a) (Tvan	Priew	0	214=	38	1	Tekru	iar	121,2008	
	-	•	MILHAEL La	ENTA 1	strar's Signa	44)	De	tens	t 476	HWA	1 Ha	NAPais	MI.	721401	
	Sta	ne	FEB 2.6.20	08	400.0	K. Ca	BARE.								

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Martia Jose Concal Ves Examinate Fight Interest Crass of House Concentration of the Control of Basic Contro		ш	1. Decedent's Name (First, Middle, Last)								Year	3. Time of Death	
Example of Part Analysis State (For example) Case y Rouse Case y Rouse Case y Rouse Social Search Number of Created Social Search Number of Created Social Search Number of Created Loss Received of Company Company Received of Company State of Company Company Received of Company Company Received of Company Co			Maria Jose Gonca	1ves								11:20 aM	
Social Scouts Number See 10 20 20 20 20 20 20 20	Examir	ner	4a. Facility Name (If not institution, give st	reet and number)		City, Town, or L	ocation of Death		4c. Coun	ty of Death			
The state of the s		- 8		7.4	//aa la at bisthe	four) If II			R Date of Birth			-	
Use an incomplete of the complete of the compl			1 🗆	_	Vr	Mon			(Month, Day	, Year)	Coun	try)	
Total State Inc. County Mary Jand Montgomery 10c. Clay, Town or Location 10 the State 10 the Stat	A 4				49				August 20	, 1730	Cape	verde island	
Section of Figure 1 Section of Figure 1 Section of Figure 2	/land ow at				10c. City, Town o	r Location					1	0d. Inside City Limits	
Section of Figure 1 Section of Figure 1 Section of Figure 2	Mary Firsh	ţō	Maryland Montgomer	у			Silv	er Spring				1 □Yes 2KINo	
Section of Figure 1 Section of Figure 1 Section of Figure 2	r 28e	irec	10e. Street and Number	<u> </u>		101	. Zip Code			10g. Citizen o	f What Coun	try?	
Section of Figure 1 Section of Figure 1 Section of Figure 2	h witi 23a o st be	a D	705 Bonifant Road				2	20905		Cape Ve	rde Isl	ands	
Section of Figure 1 Section of Figure 1 Section of Figure 2	deat	ner	11. Marital Status	2. Was Decedent E	Ever in U.S.	13. Was D	ecedent of Hisp specify Cuban.	anic Origin? (Sp. Mexican, Puerto	pecify Yes or No-	14. R			
Section of Figure 1 Section of Figure 1 Section of Figure 2	after or ite mlne			1 ☐ Yes 2 🛣 N If Yes, Give	10								
Section of Figure 1 Section of Figure 1 Section of Figure 2	ral",	d b		Year or Dates:									
Section of Figure 1 Section of Figure 1 Section of Figure 2	72 h "natu dica	ete	15. Decedent's Educ (Specify only highest grade	1 (0	Give kind o	f work done du	ion ring most of wor	king	16b. Kind of	Business/Inc	lustry		
Section of Figure 1 Section of Figure 1 Section of Figure 2	vithin sne. than	E D	Elementary/Secondary (0-12) College (1-4or 5+)							Ge	neral B	usiness	
Section of Figure 1 Section of Figure 1 Section of Figure 2	Hygie Theri Int, th		17 Father's Name (First, Middle, Last)	<u> </u>				-	ne (First, Middle,				
Security	d be i	Be								na Miran	da		
Security	should nd Me mark matic	Ĕ			19b. N	Mailing Add	lress (Street an					Code)	
Security	id 2 s Ith ar 27 Is trau				70	05 Bon	ifant Roa	nd. Silver	Spring.	Marvland	20905	,	
Security	Hea Hea tem											wn, State	
Physician Medical Examiner Physician Physician Physician Medical Examiner Physician Ph	ages ent of rt: If i			moval from State	- [1	06/2008	Burton	eville	Maryland	
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Physician Medical Examiner Physician Physician Physician Medical Examiner Physician Ph	Dep Imp any		None A. V	e cena	Lu.	Hine	s-Rinaldi O New Ham	Funeral	Home, Inc enue, Sil	ver Spri	ng, Mar	vland 20904	
Immediate a Second Continue Immediate Imme			23a. Part1. Enter the disease, or complic	ations that caused	the death. Do no							Approximate	
Sequentially list conditions cause generoe of):	Physician		Immediate Se (Final									Onset and Death	
Sequentially list conditions; larry, leading to immediate cause. Enter Underlying that initiated were resulting in death) Last resulting in the past 12 months? IF FEMALE: 23b. Was decedent pregnant at me of death of the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery Month Day rear 23d. Date of death of the cause of death of t			resulting in death)):							
The part of the pa	Examiner												
The part of the pa		je	lif any, leading to immediate Due to (or as a consequence of):										
Part 1. Cheek only one 1. Cheek on	cutec nd ransi	ami	that initiated events c.										
Second of the complete of th	e exe ian a urial-1	Ä	resulting in death) Last	Due to (or as	a consequence of):							
Second of the complete of th	ate b hysic the bu	lica	d										
Second of the control of the contr	ing plass t		IF FEMALE:										
Second of the complete of th	ath ce ttend or use	an/	23b. Was decedent pregnant	1☐Live birth	2 Fetal death							,	
Second of the complete of th	the a	sic	1 ☐ Yes 2 ☒ No		time of death	5∐ Othe	er (specify)						
Second of the complete of th	d by letach			tributing to death b	ut not resulting in t	he underly	ing cause giver	n in Part I.	23e. Did to	obacco use co	ontribute to the	he cause of death?	
Second of the complete of th	ires t signe		1	g			5 5		10	Yes 2 □ No	3 ☐ Prot	ably 4 ☑Unknown	
Second of the complete of th	requ	eted											
25. Was case referred to medical examiner; on the basis of examiner; on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25. Was case referred to medical examiner; on the basis of examiner; on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25. Was case referred to medical examiner: 1 Impatient 2 Impatient 3 I	e law has b	ldu M							autor	osy	prior to co	mpletion of cause of	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and dates of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Section (Street and Number or Rural Route Number, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850	rate icate	S	<u> </u>						1□ Yes	2 🖾 No	1 ☐ Yes	2□ No	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature	spita nours neral	C	29a. Certifier /1 🗵 Certifying Phys	ician: To the best	of my knowledge,	death occ	urred at the time	e, date and place	e, and due to the	cause(s) and	manner as s	stated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature	e Ho e Fui letely	dic	(Check only 2 Medical Examination)	ner: On the basis o and manner sta	f examination and ated.	or investig	ation, in my op	inion, death occi	urred at the time,	date and place	ce, and due t	o the cause(s)	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature	0		1 Sucare b sell	7 (A)			DO	064615		Febru	ary 25.	, 2008	
Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850	8		30. Name and address of person who co	mpleted cause of d	leath (Item 23a) (T	ype, Print)							
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature								ive, Rocky	ville, Mar	yland 2	20850		
	St	ate	31. Date filed (Month, Day, Year) FFR 2.6 200	32 Registr		1.	5.						

			_ For		State of	Marylan	d / Dep	artment of F	Health and N	lental Hy	giene	2000	0760	
			State Registrar				Ce	rtificate of	Death		Reg. No.	4000	0100	
ái	Dharaini		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yo								Vear	3. Time of Death		
H	Physicia /Medic		Mildred	d Waters	Gray				Februa	ry 20	,2008	4:55 A. M		
-	Examin		4a. Facility Name (/	f not institution, g	ive street and numi	ber)		4b. City, Town, o	r Location of Death			ounty of Death		
			HCR Mano	orCare				Larg			Pr	ince Ge	eorge's	
L,	Funeral		Social Security N		Sex 7 1 □ M 2 ☑ F	7. Age (In yrs. I	,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da	rth ay, Year)	9. Birth	nplace (State or Foreigr intry)	
D	Director		579-32-03	321	1 M 2 X F	94	Yrs.			12/12/	13		mount, Md.	
	pu >		Usual Residence of 10a. State	Decedent 10b. County		10c Cit	, Town or Le	onation					10d. Inside City Limits	
	anyta shov d at	-	Md.	P.G.		Toc. Oily		oitol Heights					1 2 Yes 2 □ No	
	8a-f	Director					- Capi							
	or 2	i i	10e. Street and Nur		_			10f. Zip Code			10g. Citizen of What Country?			
	23a ust t	<u>ra</u>	5502 Ad	oad				20743			U.S.A.			
	r dea	d by Funeral	11. Marital Status		Armed Ford	12. Was Decedent Ever in U.S. Armed Forces?		 Was Decedent of Hispanic Origin? (Specify Yeals Yes, specify Cuban, Mexican, Puerto Rican, et al., et al.			No- 14. Race - American Indian, Black, White, etc.			
9	or it			ied 2 Married	1 ☐ Yes 2 If Yes, Give	No No	lo 1 ☐ Yes 🏖 No Specify:			Specify:			African-	
2-0036	ours iral",		3 ☆ Widowed	4 ☐ Divorced	Year or Dat	Year or Dates:						poony. F	Merican	
	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)					dent's Usual Occup kind of work done	oation during most of work d)	king	16b. Kind	d of Business/I	ndustry	
2	ithin ne. nan '	d d	Elementary/Seco	ondary (0-12)	College (1-4or 5+)				d) -					
2	filed w Hygien other tl	Ö		5+ years		rs	Te	acher				Education		
2	be fil tal H d oth	Be	17. Father's Name	•	st)				18. Mother's Nam			'urname)		
Maryland 2121	2 should be find and Mental His marked ot raumatic ever	ျှ	Arman Waters						Carri	e Water	S			
<u>a</u>	2 sho and is m aum		19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	12 # Z		Mildred 3	J. Tidlir	ne/Niece				nue,Colle		,Md.	20740		
altimore,	0 0		20a. Method of Disp		☐Removal from S	20b. P	lace of Disperent of the lace	osition (Name of ematory or other pla	ce)	Date	20c. Loca	ation - City or	Fown, State	
Ĕ	it. Pages Intment of Intant: If it Injury or o			5 Other (Spec		Ft	. Linc	oln Cem.	02/2	6/08	Brentwood, Maryland			
======================================	permit. Pag Department Important: I any injury o		21. Signature of Fu	neral Service Lic	ensee	114	22. Name and Address of Facility							
n	o a m o			arry	W. Jn	att	22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 2007						C-20019	
			23a. Part1. Enter t	he disease, or co	mplications that ca	used the death							Approximate	
	Dhuaisian	14	Immediate Cause ((Final	y one cause on ea	cn iine.							Interval Between Onset and Death	
	Physician /Medical		disease or conditio resulting in death)	on	a Aspir	ration l	Prieum	nia					12 Days	
	Examiner			•	Due to (o		ience on:							

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page 2 cate

this After thi funeral

youthin 24 hours after occur.

To the Funeral Director: Af

To the Hospital or Attending

certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter underly, Cause (Disease or injury that initiated events resulting in death) Last

2 Accident

3 ☐ Suicide

4 Homicide

IF FEMALE:

Due to (or as a consequence of): Hypertension Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery Year

23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Anemia Hyperlipidemia

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

February 25,2008

Month

Day

1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 1 Natural 5 Pending

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

D66658

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rexford Babilah, M.D. 7500 Hanover Pkwy. # 101A, Greenbelt, Maryland 20770 FEB 2 7 2008

State Registrar

			Please Type or Print in				•	•).
			1 - State of Maryl State of Maryl Registrar		partment of F ertificate of			iene200	8 07681
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MICHAEL J. GRAVE	S			2. Date of Deat Month	Day Yes	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, give street and number) Prince George's Abs print 5. Social Security Number 1 🖾 M 2 🗆 F 45	rs. last birthda	ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 3	Prince Year) 1962 NO	
/land	ow		Usual Residence of Decedent	City, Town or	Location				10d. Inside City Limits
the Man	28a-f sh notified	Director	MD PRINCE GEORGE'S	LAI	NDOVER		10	0g. Citizen of What	1√ Yes 2 No Country?
ath with	s 23a or nust be		2113 VERMONT AVENUE		2078			USA	
Ind 21215-0036 be filed within 72 hours after death with the Maryland	or or neam are welling in typene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, 2 Married If Yes, Give Year or Dates:	n U.S. 1	3. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 🖾 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		merican Indian, /hite,_etc. BLACK
21215-0036 od within 72 hours af	an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		cedent's Usual Occupive kind of work done e. DO NOT use retired	oation during most of working d)	g	16b. Kind of Busine	ess/Industry
nd 21	d other th	Be Con	12TH 17. Father's Name (<i>First, Middle, Last</i>)	SEC	URITY GUAR	18. Mother's Name		PRIVATE Maiden Surname)	
	and menter Is marked aumatic e	2	RUFUS M. GRAVES 19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street	HAZEL THO	Route Number,	; City or Town, Stat	re, Zip Code)
	Item 27 I	- 8	HAZEL GRAVES/MOTHER 20a. Method of Disposition	b. Place of Dis	3 VERMONT sposition (Name of crematory or other place)	AVENUE LAN		20c. Location - City	
Pag Pag	Important: If any injury or once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	RESURR		2/28/		CLINTON, M.	
Balti permit.	lmpo any i		· Vuan Frederich		7474 LAND	OVER ROAD	LANDOVE	ER,MARYLA	
	/sician ledical		23a. Part1. Enter the disease, or complications that caused the consolections of the consolection of the c			-			Approximate Interval Between Onset and Death
60, be executed T	attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause)	sequence of):					
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r Vital ysician: ⊺	is certific director,	To Be (25. Was case referred to medical examiner. 1. Yes 2 □ No	2 ER/Outpat	tient 3 DOA Oth	26. Place of Death		e) ence 6 □Other (5	Specify)
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Tot	To the comple	Σ	29b. Signature and title of certifier Albordor Alex to Do		29c. Licens			9d. Date signed (M	19, 208
	De		30. Name and address of person who completed cause of death (SALVA Sor Sylve Try 3001	Hosp	pe, Print)	1 ve CR	overs	Man	ford
	Sta Registr		TEB 2 7 2008 \$2. Registrar's S	Ignature *		,	<i>U1</i>		(i)

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	Physicia /Medic		William Edward G	ossard		,				Februa	ry 2	6 200	8 11:27A M	
	Examin	er	4a. Facility Name (If not institution, give s			4b. Cit		Location of				County of De.		
			325 Overbrook Ro 5. Social Security Number 6. Sex		last hirthday	If Und	Ha er 1 Year	igerst		3. Date of Birt			on County inhplace (State or Foreign	
п	Funeral Director			M 2 TE	74 Yrs.	Months		Hours	Min.	(Month, Da Nov 2	y, Year)	(rth Carolina	
			Usual Residence of Decedent		/ 4					110V Z	1 19)) NO		
	how		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits	
	Ba-f s	cto	Maryland Washing	ton			gerst	own					1 ☐ Yes 2 🕅 No	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Exam her must be notified at	ai Director	10e. Street and Number 325 Overbrook Ro	ad		10f. Z	ip Code	21742			10g. Citiz	en of What C		
	n dea	Funeral	11. Marital Status	2. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Dec	edent of Hi	spanic Origin, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.)	- 1	4. Race - Arr Black, Wh	nerican Indian, nite, etc.	
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Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type	•	19b. Maili	ng Addre	ss (Street a	and Number	r o <i>r Rural</i>	Route Numbe	er, City or	Town, State	, Zip Code)	
	es 1 end 2 should b of Health and Ment fitem 27 is marked r other traumatic		Donna J. Gossard 20a. Method of Disposition		325 Place of Dispo	OVE	rbroc	k Roa	id Ha	gerste	WII M	aryland	1 21742 or Town, State	4
ב ב	Pages 1 nent of h int: If ite iry or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	amount from State	cemetery, cre-	matory of	other plac						wn Maryland	
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3	intl		30. Name and address of person who	Cornect	яп 23a) (Туре, . / / / .	(Print)	M.	die 1	/		10	Sier	108 how MO	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** Beverly Lucille GROSS February 27, 2008 2:45 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 931 Maryland Avenue Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🕱 F 75 214-28-7242 **Director** May 15, 1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TxYes 2 □ No **Funeral Director** Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 Maryland Avenue 21740 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) telephone permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick William Jones Grace Elizabeth Ludy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931 Maryland Avenue, Hagerstown, Md. 21740 Rodney Price - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 3/1/08 Hagerstown, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a cons ruence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 10 1∏ Yes this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) : After this funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

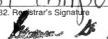
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and mariner stated. 29b. Signature and 29d. Date signed (Menth, Day, Year)

To the To the To the To the To the

State Registrar

31. Date filed (Month, Day, Year)
FEB 2 8 2008

30. Name and address of person who completed co



book

GEASTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc e877 3-11-08 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician Willie** June Harris Harris, Willie June 2/21/2008 10:50 /Medical 4h. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glade Valley Nurs. and Rehab Walkersville
f Under 1 Year | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 ☑ F 90 225-18-8236 Director 8-2-1917 VA Usual Residence of Decedent with the Maryland r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Frederick Walkersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Frederick Street USA 14. Race - American Indian, Examiner must West 21793 death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify \$ 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical filed within 72 (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Ship Yard Crane Operator permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William N. Bates Dora James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Box 858 Emmitsburg, MD 21/2/
Pate | 20c. Location - City or Town, State Edward J. Mulhern Son inlw P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greenhill Mem Gdn 2-25-2008 Clay Pool, VA. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Fundral Service Livery ee Kare 106 East Church St. Frederick, M01176 21701 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final May **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or

within 24 hours after dear To the Funeral Director: completely filled n by the

Medical

29a. Certifier

(Check only one)

29b. Signature and tille of certifier

31. Date filed (Month, Day, Year)

State Registrar death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		For State Registrar	State of Me	iryiaria		tificate of L	Death		leg. No. 2	008	07685
Physici	an	1. Decedent's Name (First, Middle, Last)	.]					2. Date of Dea Month 02/		Year Year	3. Time of Death
/Media	al	Larry Leroy Her 4a. Facility Name (If not institution, give si				4h City Town or	Location of Death	027		unty of Death	06:00a ^M
Examin	ier	Solomons Nursing					olomons			alvert	
Funeral Director		220-38-3512	M 2DE	e (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11/14/	, Year) 1940	9. Birth Cou Wash	place (State or Foreign intry) nington, DC
and		Usual Residence of Decedent 10a. State 10b. County	<u></u>	10c. City,	Town or Loc	eation					10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath end Mental Hygiene. Department of Heath end Mental Hygiene. Department of Heather 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	if Yes, specify Cuban, Mexican, Puerto R		Rican, etc.)		Black, White	, etc.		
72 hou natura lical E	eted	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	ent's Usual Occupa	ation during most of work	ing		of Business/Ir	
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Ald be fental rked c	To Be	Roy Henley					Gertru	de Marlo	ow Jon	ies	
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and lealth		Linda Wood/Daugh	nter	20h Pla	1130 S	Stagecoac	h Trail,	Lusby,	MD 20	0657 ion - City or T	Town State
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has beer ge 2 shou	Completed	-						24a. Was autor perfo		prior to d death?	topsy findings available completion of cause of
		25. Was case referred to medical					26. Place of Dear			1 ☐ Yes	2 □ No
nyslci nis cer direct	To Be	examiner?	lospital: 1 ☐ Inpatie	ent 2 E	R/Outpatien	t 3□ DOA Oth	er: Wursing He	ome 5□Resid	dence 6 [□Other (Spec	cify)
ndlng Pr th. r: After the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe I	now injury o	occurred	
al or Atte s after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At hor c. (Specify,	ne, farm, stre)	eet, factory, office		28f. Location (S City or Tox	Street and N vn, State)	Number or Ru	ıral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Medical (29a. Certifier 1 Check only one) 1 Medical Examin	sician: To the best ner: On the basis o and manner st	f examinati	vledge, death on and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) ar date end pl	nd manner as lace, and due	stated. to the cause(s)
To ti withi To ti	ğ	29b. Signature and title of certifier Charles B	ennett 1	4.0.		29c. Licens D25 .				signed (Monti $2/25/2$	
10		30. Name and address of person who co	mpleted ceuse of c	leath (Item							
		Charles W. Benne 31. Date filed (Month, Day, Year)	tt, MD 13	L845 I	I.G. T	rueman Ro	oad Lusby	, MD 20	657		
Sta Regist	ate rar		Dieses A	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P^{M} 1436 , 2008 Mollie O. Hoff Feb. 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 🛂 F 3, 1909 DC 99 Jan. Director 578-56-0787 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Md Montgomery North Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5801 Nicholson Lane #229 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Maryland 21215-0036 Specify: þ White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Harrison Jacob Ourisman Marv ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Nicholson Lane #231 N. Bethesda, Md 20852 Pages 1 and Marion Lewis Daughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 26, 08 Falls Church, Va. National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave N.W Washington D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Myocardial Infarction 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? Yes 2 12 No page 2 has certificate 1□ Yes Division or Vital filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural 5 Pending (Month, Day Year) 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Natasha Haag MD 8600 Old Georgetown Rd. Bethesda, MD 20814 30. Name and address of

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB

2 6 2008

32 Registrar's Signature

State Registrar

2 6 2008

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

4:54 a M

Montgomery

Birthplace (State or Foreign Country)

10d. Inside City Limits

16b. Kind of Business/Industry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12502 Littleton Street, Silver Spring, MD 20906

Silver Spring, Maryland

Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901

Approximate Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

29b. Signature and title of conflict

29c. License number

29d. Date signed (Month. Dav. Year)

D62435

February 24, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sayed Elsayyad, MD

9715 Medical Center Drive, Rockville, MD 20850

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23. Baltimore, Maryland 21215-0036 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot **Physician** /Medical **Examiner** The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

ral", or items 23a or 28a-f shov Examiner must be notified at

if Health if Health 27 litem 27 litem other tra

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Examine Physician/Medical þ Completed Be P

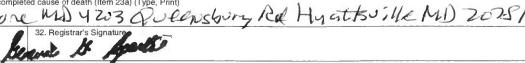
To the Hospital or Attending Physician: this After t I Director: d in by the within 24 hours To the Funeral Dir

State Registrar

Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certification: 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2008 2



Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State	State of Marylan					nd Me	ntal Hyg	jiene	2008	0/689
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1	/Medi		BARBARA							Februa	_	22, 200	
	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	f Death		4c.	County of Dea	ath
			Forestville Rehab				estv:						eorge's
	Funeral		5. Social Security Number 6. Set 118–20–3453	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day)	, Year)		rthplace (State or Foreign country)
	Director		Usual Residence of Decedent	<u> </u>	115.				J	une 9,	191	.4 Ba	hamas
	and		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
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336	or', or	by	3 ∰ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2∏ No	Specify:				Specify:	frican merican
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ō	t Hyg othe	Bec	17. Father's Name (First, Middle, Last)	2 years		Naic		18. Mothe	r's Name (/	irst, Middle, i			
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	end 2 selth a n 27 le		Stella Pressley -	Daughter	6619	Junea	au St	t. For	restv	ille, N	MD 2	20747	
Baltimore,	permit. Pages 1 end. Department of Heelth Important: If Item 27 eny injury or other tr once.		20a. Method of Disposition	20b. F	Place of Dispo	sition (Nan	ne of	a)	Dat	8	20c. Lo	cation - City o	r Town, State
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2			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the deat	h. Do not ent	ter the mode	e of dying	g, such as	cardiac or r	espiratory arr	rest,		Approximate Interval Between
/	Physician		Immediate Cause (Final	XI-zho	mer'	5 de	soci	se	End	Set	A 40		Onset and Death
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Box	ath ce tlend or use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live birth 2 ☐ Feta		DEctopic pro	egnancy				:	23d. Date of de	
	Attending Physician: The law requires that the death certif rideath. sctor: Atler this certificate hes been signed by the ettending by the funeral director, page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐ Unknown	eath 5	Other (sp	ecity)					Month	Day Year
P.0	d by	F.								00- 514			
S,	signe signe d be d	<u>م</u>	Part II. Other significant conditions con	tributing to death but not res	uiting in the u	nderlying ca	ause give	en in Parti.					to the cause of death?
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	After unera	ë	27. Manner of Death 1/€ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work		,	d. Describe h	ow injur	y occurred	
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Division	or A efter Direc in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, tarm, str	reet, factory	, office		28	City or Tow	n, State	o Number or I	Rural Route Number,
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	24 hi Fun stely	Medicai		sician: To the best of my knoner: On the basis of examina and manner stated.	wieuge, deat ition and/or in	vestigation,	at the tim , in my op	ie, date and pinion, deat	h occurred	at the time, d	ause(s) date and	and manner a d place, and di	as stated. ue to the cause(s)
U	o the omple	Me	29b. Signature and Title of certifier	and married stated.		29c	. License	number		2	29d. Dat	te signed (Moi	nth, Day, Year)
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`			20 None and address of a second state of					710	U1 -				- 0

Registrar DHMH 17 Rev 1/2001

State

1328 Southern Ave., SE Washington, DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician TE INE ขึ้นใช EANOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 13019 Victoria Heights Dr. Bowie Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 TM 1, Director 220-22-7875 92 July 1915 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13019 Victoria Heights Dr. 20715 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2ŽNo Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Management Retail permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, th once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adelaide Rice James Linton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Heine/Husband 13019 Victoria Heights Dr. Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith M.G. 2/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? (Month, Day Year) 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner tated. 29b. Signature and title of certifie

State

State 31. Date filed (Month, FEB 2 7

DHMH 17 Rev 1/2001

32. Registrar's Signa

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Day, Ye. 2008

(Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health and I State of Maryland / Department of Health and I Certificate of Death		giene Reg. No.2 0 0 8	07691
7			1. Decedent's Name (First, Middle, Last)	2. Date of De	eath Day Yea	3. Time of Death
	Physicia /Medic		Edna S. Hatton	Februa		A.A
)	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	eath
			Washington Adventist Hospital Takoma Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birtholay) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	Montgo	
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-	Magada		Usual Residence of Decedent	OCL. Z.	2, 1931 W	
	irylan show f at	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f s	cto	District of Columbia Washington			1 √Yes 2 No
	vith th	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	sath v	Funeral Director	1515 - 38th Street, SE 20020 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)	pecify Ves or No	United S	tates merican Indian,
	fter d	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerti	o Rican, etc.)	Black, W	
2000	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give Year or Dates:		Specify:	Black
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Š	hould d Me mark matic	မ	Arthur Seay Molli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru			z. Zio Code)
<u>⊽</u>	nd 2 s lith an 27 is r trau		Lawrence D. Hatton, Jr./Husband 1515 - 38th St., SE W.			
บ์	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If fine 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	
	Pages nent of h ant: If its ury or of		1⊠Burial 2 □Cremation 3 □Removal from State 4□Donation 5□Other (Specify) Ft. Lincoln Cemetery Marc	h 1, 20	08 Brentw	ood, MD
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۵	e in De		MM W - DOUBLE 4001 Benning Road	, NE Wa	shington,	DC 20019
	5 650		23a. Parth. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate vause (Final disease or condition a. CANDIAC Annes	+		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	Lxaiiiiiei	Į.	Sequentially list conditions, if any, leading to immediate b. End Stage Renal Disease Due to (or as a consequence of):			
ī	ted 1sit	Examiner	r any, leading to immediate Due to (of as a consequence of). Cause. Enter Underlying Cause (Olsease or injury			
	al-trai	xar	that initiated events cresulting in death) Last c Due to (or as a consequence of):			
00/00	fficate be executed physician and as the burial-transit					
	*= 50 m	ledical				
5	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	•
	w requires that the death cer been signed by the attendin should be detached for use	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
ב ב	at the	Phy	9 Unknown	220 Did	tabassa usa contribut	e to the cause of death?
<u>ה</u>	signed be d	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Probably 4 Onknown
ָהָם הַלְּי	requi	Completed				
ב	has t	npl m		24a. Was	ppsy prior death	autopsy findings available to completion of cause of
	sician: The law s certificate has b irector, page 2 s			1□ Yes	2 No 1 □ Y	es 2□No
5	sicial s certi irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No Hospital: 1 ☐ Inpatient 2 ② ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		o <i>ne)</i> sidence 6 □Other (S	inacifu)
5	a Phy er this eral d	2	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	респу)
5	ath. r: Afte e fun	ation	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
2	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or own, State)	Rural Route Number,
5	talon rs after ral DI					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical	29a. Certifier (Check only (C	e, and due to the urred at the time	e cause(s) and manne e, date and place, and	as stated. due to the cause(s)
	To the I	Med	one) and manner stated. 29b. Signature and title of contiller 29c. License number		29d. Date signed (M	onth, Day, Year)
	F ¥ ¥ S		1/40-	₇	2/25/	0
0	(4)		30. Name and address of person who completed cause of death (Herm 23a) (Type, Print)	1	4016) 1
<	0		7 CO A A M M	of 1	1 Panll	mb 20912
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	U		100 100
	Registr		EER 2. 7 2008 Keen & Special			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Hut chin son 8:43 AM HODDRY 2008 =1h rvay /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Desit ort 18 by and Ceci1 Oak ff Under 1 Year | If Jonder 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 220-84-1997 42 Director Delaware 1965 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Ceci1 1 ☐ Yes 2√☐ No Maryland Port Deposit Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Oak Court 21904 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Carpenter</u> Home Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Campbell Shirley McNeir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Freda Marlene Hutchinson / Wife 4 Oak Court, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) Mayerdale Crematory 23, 2008 Newark, Delaware 21. Sign July 1 Finer | Service Licence 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Non-**Physician** Hodykins 4000 homa /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical the attending phase as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an page 2 s certificate has autopsy performed 1□ Yes ZNo 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After Hospital or Attending (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident death. after death.

I Director: /
d in by the f 6 Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 052477 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gran St. Baltimar MD 21201 Rapaport 22 31. Date filed (Month, Day, Year) FEB 2 5 2008 State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Physician

Examiner

Funeral

Director

/Medical

Please	Type or Print in E					_	e.
_ For	State of Marylan				Mental Hygie	ene	
State Registrar		Cei	rtificate of	Death	Reg	g. No.2	8 07693
1. Decedent's Name (First, Middle, Las					2. Date of Death Month		3. Time of Death
Xenia Pearl F			4h City Town	or Location of Deat	FEBRUARY	25, 200	08 6:20P.M.
4a. Facility Name (If not institution, give Reeders Memorial			Boonsb		M.I.	Washin	
5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs		9.	. Birthplace (State or Foreign
232-54-3782	ex	Yrs.	Months Days	Hours Min.		Year)	Country) irginia
Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
WV Jeffers		rpers	Ferry				1 □Yes 2∑ No
10e. Street and Number 12 Chestnutwoo	od Wav		10f. Zip Code 2542	5	10	g. Citizen of Wha	at Country?
11. Marital Status	12. Was Decedent Ever in U	.S. 13. V			Specify Yes or No- rto Rican, etc.)	14. Race	American Indian,
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 🏠 No		rto Rican, etc.)	Black, \ Specify:	White, etc. White
15. Decedent's Ed (Specify only highest gra	de completed)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo	nrking 1	6b. Kind of Busin	ness/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)			ractical	3.7	Health C	are
17. Father's Name (First, Middle, Last)	1			т	ume (First, Middle, Ma		
Jacob VanBuren					Bell McIr		
19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Stree		Rural Route Number,		ate, Zip Code)
Allen Hilliard -	**	T	-				wn, WV 25443
20a. Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	I Place of Dispo cemetery, crei	osition (Name of matory or other plate) Cemeter	ace)	Date 2	Oc. Location - Cit	ty or Town, State
21. Signature of Funeral Service Licen	//		2. Name and Addr	ess of Facility Ea	ackles-Spe	encer & 1	Norton
23a. Part1. Enter the disease, or com	plications that payond the	th. Do not	er the mode of the	ing, such se acci	arpers Fer	ry, WV	25425 Approximate
23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. _aCa.du	obuln		ing, such as cardia	Lo or respiratory arre	-t ₁	Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a consec		1				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consecutive)	ment	ma ta				2 weeks
and a sum of the sum o	Due to (or as a consec	querice Of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3 🛭	□Ectopic pregnand □ Other (specify) _	зу		23d. Date o Month	,
Part ii. Other significant conditions o	contributing to death but not res	sulting in the u	inderlying cause gi	ven in Part I.			ute to the cause of death?
					24a. Was an autopsy perform	/ pric ned? dea	ere autopsy findings available or to completion of cause of arth?
25. Was case referred to medical				26. Place of Do	1 Yes 2 eath (Check only one		
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatier	nt 3 DOA Ot	hor:	Home 5 ☐ Resider		(Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inju		28d. Describe how		

Sequentially list concause. Enter Und Cause (Disease of that initiated event resulting in death) Examine Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 Unknow Part ii. Other sigr 25. Was case reference examiner?
1 ☐ Yes 2 27. Manner of De 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier Feb 26, 2008. 244996

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20311 DR. ZAFAR MALIK, LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 32. Registrar's Signature 2

08-01221 Sara F. Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sara E. Hill	rteg. No.	008 07691
Physician/ Medical Examine		3. Time of Death
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County 4705 Quadrant Street Prince Georges Hospital Cheverly	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY) Months Days Hours Min. 9-16-1941	y) 9. Birthplace (State or Foreign Wiccountry) DC
id how any r	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location CAPITOL HEIGHTS	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number	/hat Country?
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	11. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Yes 2. X No 13. Was Decedent of Hispanic Origin? (Spedify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Racc White	e - American Indian, Black, te, etc.
5-0036 ed within 72 hours afte tygiene. other than "natural", the Medical Examiner Completed by		BLACK dusiness/Industry
21215-0036 21215-0036 Mental Hygiene. marked other than "natur e event, the Medical Exami To Be Completed E		F DEFENSE
sho and and matti	ш <u> </u>	
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 mijury or other traur	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location 1 V Burial 2 Cremation 3 Removal from State crematory or other place)	- City or Town, State
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY—SPANGLE 524 — 8TH ST., N. E. WASH., DC	20002-5236
Physician /Medical = xaminer	23a. Part I. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
iner	Sequentially list conditions b. Perforation of surerior vena cava and branches	
executed and al - transit ical Examiner		
1760, ficate be executed g physician and ine buriat - transit	X UNPENDED AMENDED AMENDED THE Inne a-c, 27,28a-f, perME,g877 3/12/08 TT 4a,4b, perE 23d. Date of pregnant in the large state of pregnancy 23d. Date of pregnancy 23d. Date of pregnancy 23d. Date of pregnancy	
b. Box 6876 the death certificate by the attending phy ched for use as the l	Down was decedent pregnant in the past 12 months? 1	Day Year
P.C	1 Vos 2 No 3	ribute to the cause of death? ☐ Probably 4 ✓ Unknown
of Vital Records, ng Physician: The law requires ther this certificate has been sig- meral director, page 2 should be 1: To Be Completed	24a. Was an 24b. autopsy performed? 1 ✓ Yes 2 No 1	Were autopsy findings available prior to completion of cause of death? Yes 2 No
Vital Recysician: The Inis certificate Idirector, page	25. Was case referred to medical 26. Place of Death (Check only one)	✓ Other: Scene
ion of V tending Phys eath. for: After thii the funeral di	27 Manager of Dooth	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune- edical Certification:		per or Rural Route Number, City Hospital Cheverly, M
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	
	O.C.M.E. February 1	
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 07695 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Johnson Cathryn Dorene 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wiconico ional medical cente Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 😿 F 73 217-30-8874 Director 2/15/1935 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Wicomico Delmar Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 may Injury or other traumatic event, the Medical Examiner must be no ane. 21875 USA 8814 Mar Lynn Drive Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: white ò 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Maggie Ester Dize Charles Ross Payne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8814 Mar Lynn Dr., Delmar, MD 21875 Charles R. Filgueras/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 2/29/08 Salisbury, MD 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 ario H. (Dompson CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4) comos CA Physician /Medical Due to (or as a consequence of): Examiner CANCER صص Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown ģ signed by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu the

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 0051743 who comple d cause of death (Item 23a) (Type, Print) 30. Name and address of pe E. CARROLL St. SAlisbury Md. 21801 100 32. Registrar's Signature 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year FRANK KOWALSKI 1:37 A M FEBRUARY 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 M M 2 □ F Director 201-26-4211 76 Dec. 31 1931 Pennsylvania Usual Residence of Decedent a or 28a-f show t be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Gaithersburg Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 12615 Viewside Drive Funeral 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 (X)Yes 2 No 1953-If Yes, Give Year or Dates: 1955 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher County School System 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hi Important: If Item 27 is marked oth any injury or other traumatic eveni Be Kowalski Stefania Wojtasek ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anita Kowalski / Wife 12615 Viewside Drive, Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🔀 Removal from State 4 Donation 5 Dother (Specify) Prosperity Cemetery 3/1/08 Prosperity, Pennsylvania 22. Name and Address of Facility
Muriel H. Barber Funeral Home
P. 0. Box 5038, Laytonsville, 21. Signature of Funeral Service Licensee 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examine Toxic Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Unioning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Box 68760. Ö ۵, Division or Vital Records,

within 72 hours after death

Hygiene

is marked other

Baltimore, Maryland 21215-0036

certificate be executed and physician the as attending | for use as peen certificate To the Hospital or Attending Physician; After death. Director; the Funeral D 24 hours

Certification:

Medical

0 10+1

Brian C. Shen, 31. Date filed (Month, Day, Year) State

27. Manner of Death

1X Naturai

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier MO

and manner stated

5 Pending investigation

6 Could not be

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

D0050209

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

February 23, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

501 N. Frederick Avenue, Gaithersburg, Md. 20877

32. Registrar's Signature 2008

Registrar

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carrie Louise King February 20, 2008 7:50P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Edgewater Millennium-South River Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2\□F Director 579-34-3762 91 Maryland April 4, 1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2X No Director MD Calvert Lusby 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a USA 12955 Barredra Boulevard 20657 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Arthur Lee King Florence Estelle Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Arthur King Road, Prince Frederick, MD 20678 Evelyn Smith - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olive UM Church Cem. 2/27/2008 Prince Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardio vascular di rease Atherosclerot disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed corbin some 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 WNo 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records. within 24 hours after death To the Funeral Director; To the Hospitai

State

851-31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D. 50653

GYAN. C. SURANA

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

December Service (Addob. Lade) Lance Lan				For State Registrar		,	Cei	tificate of	Death		Re	g. No 2 0 0	8 07698
Exeminer Second County		Dhysisi		1. Decedent's Name (First, Middle,	Last)			· · · · · · · · · · · · · · · · · · ·		2			
Contract				Jan	es Kim								
Social Security Number Recommendation 1				4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, o	r Location o	of Death		4c. County of D	eath
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The property of the property				214-80-3380						Min.	(Month, Day,	Year)	Country)
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Due to (or as a consequence of): Due to (or as a consequence of):	e		ē	Sequentially list conditions, if any, leading to immediate				NCER					-
Jeg of the completion of cause of death? IFFEMALE: 23b. Was decedent pregnant in the past 12 morphe? 1 10 live birth 2 15 lives 2 more of death? 1 10 lives 2 morphe? 1 10 l		uted d ansit	min	cause. Enter Underlying Cause (Disease or injury	HY	POY-	\overline{A}						
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23d. Date of delivery 23d.	5	ag ge	Nedi	IC CCMALC.									
State	Ş	ith ce tendiir r use		23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	pf pregnan	ncy death 3□	∃Ectopic pregnanc	y				
25. Was case referred to medical examiner? 1		e dea he at hed fo	sici	1 ☐ Yes 2 ☑ No		time of de	ath 5□	Other (specify)				Month	Day real
25. Was case referred to medical examiner? 1		d by t	Phy		a contributing to death h	ut not rocui	ting in the u	ndorlying cause air	on in Bort I		23e Did tob	acco use contribut	a to the cause of death?
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TMALTK 7600 CARROLL AVENUE TAKOMA PARK, MD 20912 State 31. Date filed (Month, Day, Year) 33. Pegistrar's Signature	5	<u> </u>	ţi			y Year)	Injury			No			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TMALTK 7600 CARROLL AVENUE TAKOMA PARK, MD 20912 State 31. Date filed (Month, Day, Year) 33. Pegistrar's Signature		Atter r dear ector by the	fica	3 ☐ Suicide 6 ☐ Could no	Zoe. Flace of Inju	ury - At hor	ne, farm, str	eet, factory, office		28			r Rural Route Number,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TMALTK 7600 CARROLL AVENUE TAKOMA PARK, MD 20912 State 31. Date filed (Month, Day, Year) 33. Pegistrar's Signature		Vithin Fo the	Me	29b. Signature and title of certifier				29c. Licens	se number		2	9d. Date signed (M	onth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TMALTK 7600 CARROLL AVENUE TAKOMA PARK ND 20912 State 31. Date filed (Month, Day, Year) 37 Registrar's Signature				MI		1	Q. P	Di	5912	1		2/23/	08
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						ar's Signati	ure	aske)				•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dennis Patrick Kiley February 22, 2008 6:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9529 Beech Park St. Prince George's Capitol Heights 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 M 2 ☐ F Days Hours Min Director 217-44-3982 63 10/19/1044 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ural", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9529 Beech Park St. 20743 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th ies 1 and 2 should be filed wof Health and Mental Hygier fitem 27 is marked other the Machinist Mailing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerald Kiley Margaret Elizabeth Hardy ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda J. Kiley/ Wife 9529 Beech Park St., Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages
Department of I
Important: If Ite
any injury or of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Kalas Crematory 2/24/08 Edgewater, MD 4 □ Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 1/1/4 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each lin. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed sician and burial-trans Box 68760, physician Physician/Medical the as 1 attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) P.O. □Yes 2□No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has t le 2 s autopsy performe page ; certificate Division or Vital 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of D. ath funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:.

completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of erson who completed cause of death (Item 🔼a) (Type, Prin 31. Date filed (Month, Day, Year) FEB 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 21, 2008 **Physician** Miriam Waters Kopp 2:46P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Reeder's Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, Sept. 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Months 1 ☐ M 2 🕱 F Yrs. 216-22-8037 90 1917 ΜĎ **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Frederick 1 ☐ Yes 2 ☑ No Myersville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9369 Myersville Rd. 21773 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: þ White 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) public schools teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Leatherman Waters Altie Younkins P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Calvin Waters (Brother) 24 S. Main St., Myersville, MD 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H 3 ☐ Removal from State 1 Burial 2 Cremation Lutheran cemetery 2/25/08 Middletown, MD 4 Donation 5 Other (Specify) Donald B. Thompson Funeral Home P. 0. Box 18, Middletown, MD 21769 of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician AL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (213,423 or figury Due to (or as a consequence of): Examiner I or Attending Physician: The law requires that the death certificate be executed after death.
I Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burlansit director. that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Laknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 2 4NO 1∐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Ho Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28c. Injury at Work? (Month, Day Year) 1 | Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier att mo D16019 FFB 212008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) DR. VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 6 2008

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Aaron M. Lowry Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 16, 2008 0000 hrs Medical Examiner Aaron Mason c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Laurel 9700 Washington Blvd 9. Birthplace (State or Foreign Washington, 8. Date of Birth (MM/DD/YYYY 1976 If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) D.C. Director October 26, 578-08-4648 1 X M 2 31 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location E N 10a, State 10b. County 1 X Yes 2 No of Columbia Washington or items 23a or 28a-f show must be notified at once. District t. Pages I and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. Triant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 United States 5724 - 3rd Place, N. W. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 X Never Married 2 Married Yes Specify: Black Yes 2 X No specify: If Yes, Give Yea 3 Widowed Divorce ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Fiber Optics Technician MCT 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Deloris Lowry Michael 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3rd Street, N.W.; Washington, D.C. 20011 Dairic Patrick Brown (Brother) Feb. 27, 2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory, Inc. Donation 5 Other Specify R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 21 Signature of Funeral Service Licenses 20011 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that **Physician** Between Onset and failure. List only one cause on each line Death Medica a. Gunshot wound of arm and chest Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED ysician a burial -UNPENDED The law requires that the death certificate be Box 68760, 23d Date of delivery e attending phys for use as the bu 23c. If yes, outcome of pregnancy IF FEMALE Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has performed? 2 No certificate h ✓ Yes 2 1 🗸 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other examiner? Hospital: 1 Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursina Home 5 Inpatient 2 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury After 27. Manner of Death Police involved shooting Certification: FOUND: Yes 2 V No Natural Pendina Director: d in by the f within 24 hours after death Feb 16, 2008 0500 hrs 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 9700 Washington Blvd, Laurel, MD 3 Suicide (Specify) Hotel/Motel 4 V Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 17, 2008 O.C.M.E 181 she MA 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year Feb. 23, **Physician** John Gilbert Leavelle 1759р м /Medical 4a. Facility Name (If not institution, give street and number)

Julia Manor Nursing Home 4c. County of Death
Washington 4b. City, Town, or Location of Death Examiner Hagerstown | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | 8 - 6 - 1 9 2 7 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Funeral 1**√**M 2□F 80 182-22-2184 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Hagerstown MD Washington 1 √Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A 333Mill St. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If tiem 271s marked other than "natural", or fler any injury or other traumatic event 1 Never Married 2 Married 1 Yes 2 white 2 NO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify ģ If Yes, Give Year or Dates: 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Insurance Co. Elementary/Secondary (0-12) College (1-4or 5+) Maintennance 8th grade 17. Father's Name (First, Middle, Last)
Charles Leavelle ¹⁸ Mother's Name *(First, Middle, Maiden Sumama)* Viola Jane Leavelle Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13713 Broadfording Rd. Clear Spring, MD 19a. Informant's Name/Relationship (Type, Print) Dolly V. Reed daughter 20b. Place of Disposition (Name of September, crematory or other place)
Smithsburg Crematory 20c. Location - City or Town, State 20a, Method of Disposition Feb. Dat 26, 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg, MD 2008 21. Signature of Funeral Service Licensee Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hyber-tongive Physician Candiovas /Medical to (or as a consequence of): **Examiner** Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medicai as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Qunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 SCNo Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 052323 02-25-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-0 ma 1124 KHALID WASERM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 2 7 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year IRGINIA A M 50 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical enter La Plata hat 1V1390 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2X F Virginia 87 1920 Sept. Director 577-20-8653 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Ex-miner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11080 Weymouth Court 20603 JSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. Specify: White ò 3 ₩ Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 is marked of any Injury or other traumatic ever John Adrian Wilkins Ada Thomas Wilkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn J. Steele/ Daughter 2296 Westwood Drive, Waldorf, Maryland, 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Popes Creek Bapt. Cem. Feb. 21,2008 Montrose, Virginia 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Fuperal Service 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ter/osc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient မ 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

certificate be executed Box 68760 attending use ō signed by the a or Vital Records, P.O. has page 2:

Division

the Hospital or Attending

death.

within 72 hours after

Il Hygiene.

12 should be filed w and Mental Hygier
7 is marked other the

Maryland 21215-0036

Baltimore,

and burial-trar physician the certificate this funeral Certification: After 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 29b. Signature and title of contifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney stated.

MI

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CIVISTA Medical Center, La Plata itkes IMD 055

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month olores MAE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICOMICO ROAD ANT If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1□M 20€ Months Days Hours Min. 213-22-4651 Usual Residence of Decedent Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "neturel", or items 23a or 28a-f show treumatic event, it a Medical Examination must be notified at 1 Yes 2 10 Director WICOMICC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1840 2759 DSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ۾ 30 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Importent: If item 27 Is marked other the any injury or other treumatic event. Item. 2010. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GRAYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOKE MID 21840 aavanter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Demial 2 Cremation 3 Removal from State *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Home to HivE PO BOX GI MESSICK-FONERUL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2□ No 1 ☐ Yes 2 No 1 TYes Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☑ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DQA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 02-12 2008 01: 10 am 1 ☐ Yes 2 No NIA 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier isch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 08 PINE BLUKE 0 FOLASHADE 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02 Month Physician 2008 INA L. MITCHELL 24 2:49 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MAGNOLIA CENTER PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 08/10/1908 1 □ M 2 😿 F Months Days Hours Min. ALABAMA 416-66-6778 99 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be maritimal to 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MD PRINCE GEORGES LANHAM 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4523 KINMOUNT ROAD 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Saltimore, Maryland 21215-0036 Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE **9TH** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLIE BRANDON ZELMA COOK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4523 KINMOUNT ROAD LANHAM, MD 20706 CURTIS L. MITCHELL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/29/2008 LANDOVER, MD 4 Donation 5 Dother (Specify) HARMONY MEMORIAL PARK 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Artemoscherotic Cardiovascular **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to infine flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a nonsequence of) ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 MUnknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performeda 25. Was case referred to medical examiner? 2 🗷 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attencate after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2008

reensbury Rd Hyattsville MD 20081

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month **Physician** LAWRENCE McPHERSON FEBRUARY 27 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral №** М 2 Б 97 288-10-2189 Ohio Director May 3, 1910 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13307 Club Road 21742 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White à ΙI 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Local Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell McPherson Ferol Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra James H. McPherson 13307 Club Road, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodland Cemetery 03-07-08 Xenia, Ohio 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, hagerstown, Md. 21740 R. hoel prade 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after death.

Funeral Director: After this certificate has been signed by the attending nhysician and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 ∏Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 phopatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours at To the Funeral C 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

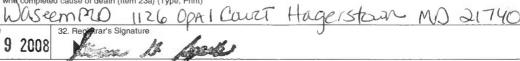
6H-2+1

State Registrar

31. Date filed (Month, Day, Year) FEB 2

luhammud

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1) 5 2 3 2 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Februare y 26 200と V4c. County of Death /Medical Mary Jessie McKinsey 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1941 **Funeral** 1 □ M 2 і X F Months Days 66 Maryland Director 216-38-2458 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a are 200. And any Injury or other traumatic course. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Maryland Washington Director Williamsport 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 U.S.A. 8531 Neck Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Aikens Stoner Warren Stoner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8531 Neck Road Williamsport Maryland 21795 Robert L. McKinsey, Sr. husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Mem Park 20c, Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mar 1, 2008 Williamsport Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or conficiations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cule **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiomi burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a d be detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဂ္ 1 Hipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUR ARID 31. Date filed (Month, Day, Year) FEB 2 8 2008 State Registrar

Division or Vital Records, P.O. Box 68760, within 2

> State Registrar

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FEB 2 5

Melanie

31. Date filed (Month, Day, Year)

GERRIOR M.D

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Memorial

18.2008

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Eva Mach-Dixon February 21, 8:04 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😿 F 219-59-9913 71 Director 3/7/1936 Germany Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4115 Water View Dr. 21037 Germany 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after I ☐ Yes 2 💢 No f Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ White 3 Widowed 4 Divorced Completed item 27 Is merked other than "natu other treumetic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4_{vrs} Teacher <u>Education</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental h Emil Krauss Gerda Streiter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is m any injury or other treum Thomas O. Dixon, Sr./Husband 4115 Water View Dr., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 2/26/08 4 Donation 5 Other (Specify) Suitland, MD 21. Signatur Phera Pervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 201 lec /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to infraoduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2/No Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy 1□ Yes 2 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 Inpatient 2 ER/Outpatient 3 ☐ DOA this anner of Death of Injury 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pwithin 24 hours after death.
To the Funeral Director; After t 28c. Injury at Work? Certification: Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day) Year) cense number

Sta

State Registrar 30 Nameland

31. Date filed (Month)

ddress of person

who completed cause

5 2008

DHMH 17 Rev 1/2001

OFLIGINAL

f death (Item 28a) (Type

jistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 1955M 2 08 HUR aа /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Mandarin Hospice House Harwood 6. Sex M 2□ F 9. Birthplace (State or Foreign if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 30 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours ^{Year)} 1917 Yrs. Maryland 212-05-0961 90 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at MD Anne Arundel Arnold 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or any nlury or other traumatic event, the Medical Examiner must be 1 USA 856 Wilson Road North 21012 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 WW II 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Helen Wilson Arthur T. Moxley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 291 Locust Ridge Road Arnold, MD 21012 Becky Hoppa/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 27, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Glen Burnie, MD 4 □ Donation 5 □ Other (Specity) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Barranco & Sons, 495 Gov. Ritchie Severna Park Funeral Home Severna Park, MD 21146 Hwy. 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be execute Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 🔀 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2000 Other: 4 Nursing Home 5 Residence Hospital: 2 ER/Outpatient 3 DOA 2 1 Yes 1 Inpatient 6 Other (Specify) this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide determined 4 | Homicide 1 24 hours a 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

To the

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTA

2008

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W Registrar's Signature 29c. License number

ENSE HOHWAY ANNAPOUS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Molnar 1:40A Arthur February 22. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown ours Min February 19,1923 Birthplace (State or Foreign Country) **D**Λ If Under 1 Year Months Days Social Security Number Age (In yrs. last birthday **Funeral** Hours 1 M 2 □ F PA 200-12-2933 85 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director MD St. Mary's Leonardtown 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 21585 Peabody Street 20650 USA Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s any or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. TYes 2 □ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify White 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Airplane Mechanic Airlines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Schawu John Molnar ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other training once. 12605 Trinity Drive, Charlotte Hall, MD 20622 Marlene Waddel/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 3/4/2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. M00945 22. Name and Address of Facility 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. St. 211 Mary 's Ave. Is Plats, MP 20646 dying, sur as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending phys for use as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 S No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerai Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

James Jarboe, M.D. 215\$5 Peabody St. Leonardtown, MD

29b. Signature and title of

ause of death (Item 23a) (Type, Print) rson who completed 30. Name and address of

32. Registrar's Signature 31. Date filed (Month, Day,

made 2008

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

08-01519 Timothy McClellan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 07712

	ary weeren		-For State Certificate of Death	F	Reg. No.		0 0 7 7 1 -
	Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ath Day	Year	3. Time of Death 1602 hrs
Vled	ical Exami	ner	Timothy James McClellan	Month February	21, 2008	1 of Dooth	
1			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. Cour	nty of Death	1
			University Hospital Baltimore City 5. Online County Number 16. Say 17. Ann (In yes last hirthday) If Under 1 Year Iff Under 24Hrs.	To Date of B	irth/MM/DD/XX	VVVI 9. Birt	hplace (State or Foreign
	Funeral	1	5. Social Security Number 0. Sex Months Days Hours Min.	7	9/1983	Cou	untry)
	Director		223-53-0503 XX _M ₂ F 24 Yrs. World's Days Hours Willing	07709	7/1903	VI	rginia
	A	1	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
	w an					•	1 Yes 2 X No
	Maryland 28a-f show any d at once.	tor	Virginia Fairfax Fairfax 10e. Street and Number 10f. Zip Code		10g. Citizen of	f What Cour	ntry?
	: Mary r 28a	Director	Toe. Street and Number	ļ	U.S.A		1
	ith the 23a o notif	ral D	44 Martial Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	ecify Yes or N	lo- 14. R	Race - Ameri	ican Indian, Black,
	ath wi	Funer	1 XXNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	٧	Vhite, etc.	
	ter de	F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Spec	cify: Wh:	ite
	urs af Itural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the complete of the compl	vork done red)	16b. Kind o	of Business/I	Industry
1	72 ho n "na al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	,	Arta	& Cra	afte
1	ithin ene.	ם	12 Manager 18. Mother's Name	(Eiret Middle	1		
1	215-0036 be filed within 7 ntal Hygiene.	၂ ပိ	17. Father's Name (First, Middle, Last) John M. McClellan Michele			,	
\	D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho atic event, the Medical Examiner must be notified at once	Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route N	umber, City or	Town, State	e, Zip Code)
	MD 2 d 2 shoul lth and N n 27 is n	ြို	John M. McClellan - Father 4420 Majestic Lane H				
	and 2 lealth tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Loca	tion - City or	r Town, State
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		1 XXBurial 2 Cremation 3 Removal from State crematory or other place) Gate Of Heaven Cem. 2/2	29/2008	3 Silv	er Sp	ring, Maryla
	Baltimore, sermit. Pages 1 a Department of He Important: If ite injury or other t	l.	4 Donation 5 Other Specify:	VERLY 1	FUNERAL	HOME	
	Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		Hory Mahuell 10565 Main Street	Fairt	fax, VA	2203	0
	Physician	_	23a. Par J. Inter the its ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure List only one cause on each line.	or respiratory	arrest, shock, o	or heart	Approximate Interval Between Onset and
	/Medical		Immediate Cause (Final disease a. Complications of Head Injury				Death
	caminer	•	or condition resulting in death) Due to (or as a consequence of):				
		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Ę	cause. Enter Underlying Cause C.				
	si d	Examiner	events resulting in death) Last Due to (or as a consequence or).				
	xecuted n and - transit	1 7	M UNPENDED AMENDED 23a,27,28a-f per ME g879 5/2/08 amh				
	760, cate be exe physician a	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. D	ate of delive	ery
	876 iffcat ug physis the			ancy	Mo	onth	Day Year
	tal Records, P.O. Box 687 cian: The law requires that the death certific certificate has been signed by the attending rector, nage 2 should be detached for use as it	sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)				
	Bo e dear the ar	١	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco use	contribute !	to the cause of death?
	P.O. ss that the gned by e detach	<u>م</u>					robably 4 🗸 Unknown
	S, F uires an sign ld be	P 0		24a. W	/as an	24b. Were	autopsy findings available
	ord w req as bee	1 2		· p	utopsy erform <u>ed</u> ?	death?	
	Records, The law requir ficate has been s	Completed			es 2 No	1 🗸	Yes 2 No
	al Fish:	8	25. Was case referred to medical	ing Home 5	Residence	e 6 Oth	ner:
	of Vital Recing Physician: The Latter this certificate Latter this certificate Latter director, page	3	1 V Yes 2 No		ibe how injury		
	Jing Pl		7/ Manner of Death 120a, Date of injury 200, 1	Cubina	1+	-od	
	SiOr Vitend death death sctor:		2 Accident 2 Accident 2 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locati	t_assault on (Street and	Number or I	Rural Route Number, City
	Division tal or Attendinrs after death.	ortification.	3 Suicide 6 Could not be determined (Specify) Street	or Tov 325 N I	_{vn, State)} Varket, St	Fred	erick,MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commenced filed in whe fineral director, page 2 should be detached for use as the burial - transi	ے ا	29a Certifier . The last of multiplication death occurred at the time date and place, as	nd due to the	cause(s) and r	nanner as st	tated.
	the H iin 24 the Fu	Modical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, o	date and place	, and due to	the cause(s)
	To To	No.	and manner stated. 29b. Signature and title of certifier 29c. License number				Month, Day, Year)
4			O.C.M.E.		Febru	ary 22, 2	8008
			30. Name and address of person who completed cau tof death (Item 23a)		=		
			Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201			
		Sta	e 31. Date filed (Month, Day, Year) 2008 Registrar's Signature		OCME		
	Reg	istra	WHY II TOO				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. **Physician** 21, 2008 Joseph Howard Mann 10:15P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7102 Unakite Ct. Middletown 8. Date of Birth (Month, Day, Year) Frederick 9. Birthplace (State or Foreign Country)
30 PA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 203-22-2493 1930° Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show must be notified at Frederick 1 ☐ Yes 2XXXo Director Middletown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7102 Unakite Ct. 21769 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self-employed photographer photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Walter Mann Lavina Pearl Slicker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVerne Mann (Wife) 7102 Unakite Ct., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or hiller blace) Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State Jefferson Memorial 2/26/08 Pittsburgh, PA 5 ☐ Other (Specify) Si nature Donald B. Thompson Funeral Home 0. Box 18, Middletown, MD 21769 blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on early line. Enter the disease, or or heart failure. List Immediate Cause (Final Physician Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disassor Lijur) that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant fonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe 2 ☐ No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this (5 Residence 6 □Other (Specify) 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30-25 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 10 Oboll 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01526 State of Maryland / Department of Health and Mental Hygiene Line 12/26708 Certificate of Death Bryan Scott Myers 2008 07714 1. For State Amended Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 21, 2008 2258 hrs Medical Examiner Bryan Scott Myers 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Frederick Memorial Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (in yrs. last birthday) **Funeral** oreign Min. Months Days Hours Country) MD FEB 25 1967 Director 215-04-0390 39 40 Yrs 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No s 23a or 28a-f show e notified at once. Frederick Brunswick MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21716 USA 620 Brunswick Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? 1 X Never Married 2 2 x No Yes White Specify: Yes 2 X No specify: If Yes, Give Year Widowed 4 Divorced item 27 is marked other than "natural", traumatic event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Guilford Drive College (1-4 or 5+) Elementary/Secondary (0-12) WalMart Baltimore, MD 21215-0036 Clerk/Stocker of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sylvia Lee Feaster Ronald G. Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 912 East F Street, Brunswick, MD Ronald G. Myers, Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State or other Park Heights Cemetery 2/26/08 Brunswick, MD Other Specify: 22. Name and Address of Facility 21. re of imeral Service Li enser Barbara A. William Uwner John T. Williams Funeral Home 100 Petersville Road, Brunswick, Williams, 21716 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Acute Myocardial Infarct Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ca AMENDED ysician a UNPENDED Physician/Medi Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: ned by the attending phy-detached for use as the b Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ğ Completed 24b. Were autopsy findings available 24a. Was ar certificate has been ector, page 2 should prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital: 1 Other₄ Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this No 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification 1 V Natural Yes 2 No n 24 hours after death. ie Funeral Director: A tetely filled in by the fu 5 Pending 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 22, 2008 O.C.M.E. rol 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 10 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month Pay, Y2ar) 6 32. Registrar's Signature State 2008 die se se se Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 11:40 AM MA RCH FUCENE /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE CI HOPKINS HOSPITAL THE. JOHNS BALTIMORE CITY Birthplace (Stete or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) July 27, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1√2 M 2□F Months Yrs 66 Director 218-38-1280 10d Inside City Limits 10c. City, Town or Location 10b. County 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: If item 27 is marked other than "natural", or Items 23a or 28a-f show and if it is not other treumatic event. It a Medical Examinant part be notified at any or other treumatic event. 1 ☐ Yes 2 No Hancock MD Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21750 USA 4763 Casper Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: White 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 10 Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Melvin H. Miller Margaret M. Roach ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald L. Miller/Brother 16771 Taylors Landing RD Sharpsburg, MD 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 03/08/2008 Berkeley Springs, WV Greenway Cemetery ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 W.Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or corriplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SHOO 4 HOURS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Completed by Physician/Medical as the esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy Year Month Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 2 No 3 Probably 4 Unknown 1 🗀 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 s 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. n 24 hours after death ne Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier

RES

HOPKINS Hospital 600 North wolfe street Bultimore, Marilland 21287

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

ORIGINAL

32. Registrar's Signature

XLV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sania Zubair, The Johns

31. Date filed (Month, Day, Year)

Medical Dactor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 12:14 PM 3 McCormick 3 2003 Gene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimare
Under 1 Year | If Under 24 Hrs.
Days | Hours | Min. University of Nayland Medical
5. Social Security Number 6. Sex/ 7. Age Center Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 231-24-6200 10-15 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 2114 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No ò Year or Dates: DHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GASA ELECTRIC CO. Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 152 RUDEERO SEVERNA HARK. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addr ss of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. Fundal Service Licenses 21. Signatura 2601 Mountain Road - Pasadena MD, 21122 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** Brain ~ I day Nonsurvivable Traumatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed DALOH WALKATED BY MEDIUM BRYMINE and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Records, P.O. the detached 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ ¥65 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1□ Yes 2 410 Division or Vital To the Hospital or Attending Physician; 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Hnpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death within 24 hours after death. To the Funeral Director: After Certification: (Month, Day Year) Injury 1 □ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Fall Down Steps 15:30 2 Accident -2-08 completely filled in by the 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check on one) 29d. Date signed (Month, Day, Year) title of certifier 29c. License number 29b. Signatur 3-3-08 dress of person who completed cause of death (Item 23a) (Type, Print) ALMAAS SHAIKH S 22 Greene Street, Baltimare MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

(3)

DHMH 17 Rev 1/2001

ORIGINAL

Jerome Pinkney Milton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 16, 2008 Year 0303 hrs **Medical Examiner** Milton Pinknev <u>Jerome</u> 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Indian Head Hwy (Rt. 210) @ Pine Drive Accokeek 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Days Min Months Hours Director 04/05/1966 1 X M 2 F Yrs 217-72-7559 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County 1 X Yes 2 No 28a-f show Maryland Charles LaPlata item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at once.</u> death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 424 Patuxent Court 20646 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 2 X Married 1 Never Married 2 X No 1 Yes Specify: Black Yes 2 X No specify: If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 Superior Vault 12 Skilled Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pinknev Mary John Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 20646 Mary Waul/ Mother 7850 Crain Hwy. LaPlata, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/25/08 Clinton, Maryland Resurrection tant: Department Donation 5 Other Specify. 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Euneral Service Licenses 20605 Aguasco Rd. Aquasco, Maryland20608 00 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed ficate has been si page 2 should t 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other Residence 6 🗸 Other: Scene examiner? DOA Nursing Home 5 ER/Outpatient 3 ဥ 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Feb 16, 2008 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Pedestrian struck by auto Certification: 0301 hrs Yes 2 ✔ No Natural Pending death. Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Could not be or Town, State) Indian Head Hwy (Rt. 210)@ Pine Drive, Accokeek, MD Suicide determined within 24 hours a (Specify) Major Road / Highway 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 17, 2008 O.C.M.E. no 0aNh 30. Name and address of person who com doed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State 6 200 BURN Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** РМ Carl Alexander Pugh March 2008 1405 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ceci1 Union Hospital E1kton If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F Months Days Director 217-01-6103 95 May 30, 1912 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner πust be notified at 1 ▼Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 by Funeral 1 Price Drive <u>United States</u> Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced White Completed d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Paper Roller Operator Paper Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Ray Pugh Irene Beatrice Young ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Pugh/Grandson 133 Creek Drive, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. March 6. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Cherry Hill, MD 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. DAy Immediate Cause (Final RESPIRATOR 5ATLURE Physician CARDIO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPS15 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qué to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed YE/MS ARRHTHOLA and Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) ed by the a 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

V. Nonyaw

118 NORTH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

DIC

29c. License number

00065733

ELKTUN, MD-21921

Narayana V. Pula, M.D.

29d. Date signed (Month, Day, Year)

03/04/2008

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) FEB 26

2008

Registrar's Signature

			Please Type or Pri				Ensure Al	_	_	
			For State Of Wi	arylan	•	rtificate of			Reg. No. 200	8 07720
		0	Decedent's Name (First, Middle, Last)					2. Date of De	eath	3. Time of Death
	Physicia /Medic	-	George W. Ros	e. Sr				Month Februa	Day Yea	
	Examin	_	4a. Facility Name (If not institution, give street and number))		4b. City, Town, o	r Location of Death		4c. County of D	eath
	<u> </u>	_E_	4716 Fable Street 5. Social Security Number 6. Sex 7. Ag	no (In vre	last birthday	Capitol If Under 1 Year	Heights If Under 24 Hrs.	8. Date of Bir	Prince (George's Birthplace (State or Foreign
н	Funeral Director		1 M 2 □ F	де (III yis. i	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year) 2, 1930 Vi	Country)
	stratific according		226-32-6546 Usual Residence of Decedent				.1	reb. 22	1930 VI	
	arylan show dat	_	10a. State 10b. County	1	y, Town or L					10d. Inside City Limits 11√2 Yes 2 □ No
	the Ma	Director	Maryland Prince George's 10e. Street and Number	La	фтгот	Heights		1	10g. Citizen of What	
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	death ms 23	Funeral	4716 Fable Street 11. Marital Status 12. Was Decedent	Ever in U.	.S. 13.	Was Decedent of H	<u>3</u> Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	United St	merican Indian,
9	after or ite mine	Fu	Armed Forces' 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ If Yes, Give			1 ☐ Yes 2 ♣ No		nicari, etc.)		African
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 ₩ Widowed 4 □ Divorced Year or Dates:		160 Door	edent's Usual Occup			, ,	American
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212	filed withir Hygiene. other than ent, the Me	ome	Elementary/Secondary (0-12) College (1-4or 12 years	5+)	News	paper Pre	ss Operat	or	Private	
	e filed y other i	BeC	17. Father's Name (First, Middle, Last)						e, Maiden Surname)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	To I	Willie Rose				Nannie	<u>-</u>		
Nar	12 shu hand risma raum		19a. Informant's Name/Relationship (Type. Print) Robin Rose - Daughter						ber, City or Town, Stat Lngton, DC	
	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b. F	Place of Disp	osition (Name of	1	Date	20c. Location - City	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	9	-	ematory or other pla	i	5 2009	 Middleb	ra VA
Ħ	mit. F partme portan injur		21. Ship in A of Fun all Savice Licensee	50	TOM C	emetery 2. Name and Addre			Funeral Ho	
ä	permir Depar Impor any ir once.		windth, rond	d'L					shington, l	DC 20019
P			23a. Partt Dater the disease, or complications that cause shock, exheart failure. List only one cause on each	d the deat line.	h. Do not er	iter the mode of dyi	ng, such as cardiac	or respiratory	arrest,	Approximate Interval Between Onset and Death
a di	Physician					iratory .	Arrest			Onder and Bodan
	/Medical Examiner		Due to (or as ASHD	s a conseq	uence of):					
	*	e		s a conseq	juence of):					
	executed n and ial-transit	Examiner	Sequentially list conditions, it is y beautiful to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events b. Due to jor as the cause of the condition							
ó	- G -	_	resulting in death) Last Due to (or as	s a conseq	juence of):					
9289	eath certificate be attending physicie for use as the bu	lical	d							
9 ×	certific ding p	/Med	IF FEMALE: 23c. if yes, outcome	e of pream	ancv				23d. Date of	dolivon
Вох	eath atten	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	2 🗌 Feta	al death 3	□Ectopic pregnanc	У		Month	Day Year
0	t the d by the ached	hysi	9☐Unknown 9☐Unknown							
S, P	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medical	Part II. Other significant conditions contributing to death	but not res	sulting in the	underlying cause gi	ven in Part I.			e to the cause of death?
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ěč	e 2 sh	nple						24a. Wa:	s an 24b. Were prior commed? deat	e autopsy findings available to completion of cause of b2
alF	Th.							1□ Yes	2√2 No 1□	
Vital	Physician: this certificral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input	tient 2	1 EB/Outpatie	ent 3 DOA Ot	26. Place of Dea		one) sidence 6 □Other (8	Specify)
ō	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of In	jury	28b. Time Injury				how injury occurred	5,500.197
io	Attending r death. ector: After	atio	2 Accident investigation	ay rear	linjury		Yes 2 □ No			
Division	l or Atte after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of ir building, €	njury - At ho etc. <i>(Specif</i>	ome, farm, s	treet, factory, office			(Street and Number o own, State)	r Rural Route Number,
Ω	Hospital of the hours of Funeral D fely filled in	Se	29a. Certifier 1 栏 Certifying Physician: To the bes	et of my kny	owledge des	ath occurred at the t	ime date and place	and due to th	e cause(s) and manne	er as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) Check only one Check one Check only one Check one Check only one Check only one Check only one Check on	of examina	ation and/or	nvestigation, in my	opinion, death occu	rred at the time	e, date and place, and	due to the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (N	fonth, Day, Year)
) Mal	19		D847	12		February	22, 2008
1	(2)		30. Name and address of person who completed cause of	,						
			Madhu K. Mohan, M.D. 6	502 K	enilwo	orth Ave	#100 Rive	rdale,	MD 20737	
	Sta Registi		FEB 2 7 2008 See 1	y A	at re					
				-						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day RHODES 23 2008 14 FRANCES FEB 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 1 □ M 2 🔀 F Pennsylvania May 8, 1926 209 20 4746 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21044 6334 Cedar Lane 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hotel Industry 8 Executive Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6001 Majors Lane #5 Columbia, MD 21045 Gloria Conway-Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 2-27-2008 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M010444112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS 1 DAY disease or condition resulting in death) Due to (or as a consequence of): URINARY TRACT INFECTION Due to (or as a conse juence of): HCUTE RENAL FAILURE Due to (or as a consequence of): MELLITUS DIABETES 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24a. Was an

Physician /Medical Examiner Examiner

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funeral director,

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After 1

Physician/Medical

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Completed

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Certification: To

Medical

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physician

attending

that the death certificate be executed

Box 68760,

Records, P.O.

Division or Vital

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

a or 28a-f show t be notified at

'natural', or items 23a dical Examiner must t

the Medical

be filed within 72 hours after death with ntal Hygiene.

h and Mental h

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

by

Completed

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 2 No

25. Was case referred to medical examiner? Hospital 1 Yes 2 No

26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.☐ Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year)

27. Manner of Death Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

Suite 110

29b. Signature and title of certifier DIE MD

00053150

Columbia

02 State Registrar

Hospital or Attending P 24 hours after death. Funeral Director: After t

To the Hospital or within 24 hours at To the Funeral D

31. Date filed (Month, Day, Year) FEB 26 2008



9650

			For State Registrar	State of Mary			if Health a of Death	and Mental H	ygiene Reg. No. 2	800	07722
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Matthe	w E. Russ				2. Date of Month Febru	Day	2008	3. Time of Death 7:10 A M
	Examin		4a. Facility Name (If not institution, give stra Howard County Gener	,	11	Colum			Hov	nty of Death ward	
*5	Funeral Director		144 16 ///2	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Your Months Da		Min. 8. Date of Month, Dec 1.	Birth Day, Year) , 1922	9. Birthpl Count New	ace (State or Foreign try) Jersey
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Howard 10e. Street and Number 9017 Side Hill Road		e. City, Town or Lo				10g. Citizen o		
9500-5121	filed within 72 hours after death with the Marylar Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notitied at	Completed by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Was Decedent Ever Armed Forces? 1≅ Yes 2 ☐ No If Yes, Give Year or Dates: William tion completed) College (1-4or 5+)	III 16a. Dece	1 □ Yes 2 2 dent's Usual O	No Specify:		Special 16b. Kind of	WN11 Business/Ind	etc. te
yland 2	be filed tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Joseph Russ		5a			er's Name <i>(First, Midd</i>			laustry
Mar	12 shout hand hand hand hand trauma	ĭ	19a. Informant's Name/Relationship (Type Ann M. Russ/Wife	. Print)			reet and Numb	er or Rural Route Nur Ellicott C			Code)
saitimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Ob. Place of Dispo cemetery, crea Garrison	esition (Name of matory or other Forest	r _{place)}	Date 3-3-2008	20c. Location Owings	n - City or To	s, MD
pa	permit Depar Impor any in		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the	4	112 Old	d Columb	^{ity} Harry H. bia Pike E s cardiac or respirator	llicott		
8/60,	Physician / Medical Examiner and physician and physician and the p	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it may be done to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Pneumonia Due to (or as a co Congestiv Due to (or as a co Renal Fai Due to (or as a co Cardiomyco	nsequence of): re Heart nsequence of): Lure nsequence of):	Failure	e				
O. Box 6	that the death certificated by the attending posterior is detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome pf pi 1□Live birth 2□ 4□Pregnant at time 9□Unknown	Fetal death 3	⊒Ectopic pregn □ Other <i>(specif</i>				Date of delive Month	ery Day Year
Records, P	requires	Completed by Pr	Part II. Other significant conditions controlled Coronary Artery Di		ot resulting in the u	nderlying cause	e given in Part I	24a. W	Yes 2 No as an 24 ttopsy	b. Were autoprior to condeath?	ne cause of death? ably 4 [3t]nknown psy findings available inpletion of cause of 2t No
DIVISION OF VITAL	I or Attending Physician: The law after death. Director: After this certificate has the by the funeral director, page 2 s	Certification: To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Ho: 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	spital: 1 Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury - building, etc. (S	At home, farm, sti	f 28c.	Other: 4 Nothing Nother: 4	e of Death (Check on ursing Home 5 Record Property 1984). Descrit 28f. Location	v one)	Other (Specify	V)
_	Hospital 4 hours Funeral tely filled	Medical Ce	29a. Certifier (Check only one) 1 XCertifying Physic 2 Medical Examine								
,	To the within 2 To the complet	Me	29b. Signature and title of certifier	70		D5	cense number		29d. Date sig	24, 20	
8	Sta	ate	30. Name and address of person who com Dr. Kenneth Geh 300 31. Date filed (Month, Day, Year) FFB 2.6 200	Armory Pl	Suite 30		more, M	⁄D 21201			

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State of Maryland / Department of Health and Mental Hygien 🖰 🕦 🦠 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PATRICIA STABLER Μ. February 25,2008 9:50 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY FRIENDS NURSING HOME SANDY SPRING
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□M 2**X**)F 69 Vrs 217-42-1792 17 1939 Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Md. Montgomery Laytonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 United States 238 5210 Damascus Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth ery injury or other treumatic even ODGE. Be Edith Stiles Allie Messer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5210 Damascus Road, Laytonsville, Md. W. Drew Stabler / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2/26/08 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. mure 20882 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Signet Lell Caraforna **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Attending Physicien: The law requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of). Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? artery disease 1 Yes 2 No 3 Probably 4 Honknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 2 No 1 Yes Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 28c. Injury al Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide within 24 hours after To the Funerel Dire 6 To the Hospitel 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Clust of repeus February 25,2008 D39793 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher J. Mays, mo 1814 Poince Philip Dr. Olnoy, mb 20832 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, 10

	State of Maryland				Mental Hy	giene2 [108	07724
	1 - State Registrar	Cei	rtificate of D	eath		Reg. No.		,
ian	1. Decedent's Name (First, Middle, Last)				Date of De Month	ath Day	Year	3. Time of Death
cal	Kenneth W. S	purri			Februar		2008_	1:30a M
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Dea	ath	4c. Count	y of Death	
1	8017 Fieldstone Drive			erick	- 10-1 (8)		rede	
	5. Social Security Number 6. Sex 7. Age (In yrs. Ia	Yrs.	If Under 1 Year Months Days	Hours Mir	n. (Month, Da	y, Year)	9. Birth	place (State or Foreign oftry)
	212-38-8479 67 Usual Residence of Decedent				Oct. 15	1940	l Ma	aryland
		Town or Lo	cation				1	10d. Inside City Limits
to	Maryland Frederick Fred	lerick						1 ☐ Yes 2 K No
rec	10e. Street and Number	CIICK	10f. Zip Code			10g. Citizen of	What Coul	ntry?
0	8017 Fieldstone Drive			21702		Unite	d Sta	tes
Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S	3. 13. 1	Was Decedent of Hist	panic Origin?	(Specify Yes or No	- 14. Ra	ce - Americ	can Indian,
F	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		f Yes, specify Cuban		eno Hican, etc.)		ck, White,	etc.
b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2M No	Specify:		Speci	ry: V	Vhite
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done du	ion ring most of w	vorkina	16b. Kind of E	Business/In	dustry
gu	Elementary/Secondary (0-12) College (1-4or 5+)	`life. I	DO NOT use retired)					
ပ္ပြဲ	12	C	abinet Mak					net Shop
Be	17. Father's Name (First, Middle, Last)		1	8. Mother's N	ame (First, Middle	, Maiden Surna	me)	
2	William Webster Spurrier				. Stull			
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street an	nd Number or i	Rural Route Numb	er, City or Towr	ı, State, Zi,	o Code)
1	Cinda J. Spurrier/ Wife	8017	Fieldston	e Driv	e, Frede	rick, M	aryla	nd 21702
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, crei	natory or other place))	Date	200. Location	- Only or 11	own, State
			et Cemeter				ick,	Maryland
	21. Signature of Juneral Service Licensee	$ \hat{S}^2 $	Name and Address Lauffer Fu	of Facility ineral	Homes P.	Α.		
	That ONGUN	1	621 Opossu	ımtown	Pike, Fr	ederick	, Mar	yland 21702 Approximate
	23a. Part1. Enter the disease, or complicate ns that cause 1 he death. shock, or heart failure. List only or be ause on each line.	Do not ent	er the mode of dying,	such as card	iac or respiratory a	rrest,		Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	ive	~ son	Horge	eal c.	1-c/ma	·>	14-
	Due to (or as a consequence	ence of):		500				_
<u>in</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	ence of):					-	
ij.	Cause (Disease or injury							
Examiner	that initiated events resulting in death) Last	ence of):						
dical								
ğ	Q.							
N/S	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant					23d. D	ate of deliv	rery
cia	in the past 12 months? 1		∃Ectopic pregnancy ∃Other <i>(sp</i> ec <i>ify)</i>			N	lonth	Day Year
hys	9 ☐ Unknown 9 ☐ Unknown							
y P	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause given	in Part I.	23e. Did	tobacco use cor	ntribute to 1	the cause of death?
Completed by Physician/Me	multiple long	me	K-75/1750	-ノ	_ 1 🗆	Yes 2 No	3 ☐ Pro	bably 4 □Unknown
olete					24a. Was		. Were aut	opsy findings available ompletion of cause of
E O					- auto perfe 1 Yes	psy ormed? 22 No	death?	2 No
a a	25. Was case referred to medical			26. Place of D	eath (Check only			
To B	examiner?	R/Outpatier	Othor		Home 5 Res		her (Speci	ify)
	27. Manner of Death 28a. Date of Injury	28b. Time o Injury	f 28c. Injury : Work?			how injury occu		
atio	1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	пдагу		es 2∐No				
iffic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hor building, etc. (Specify,	ne, farm, str	eet, factory, office			Street and Nun wn, State)	ber or Rur	al Route Number,
Ser								
Medical Certification:	29a. Certifier (Check only case). 2 Medical Examiner: On the basis of examinating the case of the case							
Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. Date sign	ed (Month	, Day, Year)
		210	214	0 22		E-h	0	£ 2000
	30. Name and address of person who completed cause of death (Item	23a) (Type.	10 2146 34 F-6 25, 3008					
	P. Gregory Rayson, MD FAG	CP 5	01 West	non	St Fred	denck	WF	21701
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signation (Section 1) 32. Registrar's Signation (Section 2) 33. Registrar's Signation (Section 2) 34. Registrar's Signation (Section 2) 34. Registrar's Signation (Section 2) 34. Registrar's Signation (Section 2) 35. Registrary (Section 2) 35.	ure	bente				,	
rar	FEDA (ZUUD TURE	1 1	Dead					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Item: Ide per F.H. G-879 5/30/08 rep.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 22, **Physician** 2008 10:22A M FLORENCE VIRGINIA SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2ØF MD. 220-30-8840 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ZYes 2 No FREDERICK FREDERICK MD. Director 10g. Citizen of What Country? 10e. Street and Number 412 West South St. Apt. USA 21701 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify. Specify: BLACK Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRIVATE PAMILY College (1-4or 5+) Elementary/Secondary (0-12) DOMOSTIC 10 111 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BUTCHER GREENE FLORENCE NORMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26 EAST GREEN St. WESTMINSTOR MO. 21157 Item 27 i WAYNE A. SON SMITH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MARCH 1, 2008 PREDERICK MS. FAIRVIEW COM. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS FUNCTION HUME 21. Signature of Funeral Service Livers 21701 suy a. 110 WEST SOUTH ST PREDERIER MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Infarction Examiner Myocardice Sequentially list conditions, Due to or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 12 10 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 2 No 2 ER/Outpatient 3 DOA 1 🔲 Yes 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? After Medical Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Estel D0064624 22,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th St FREDERKE MARYLAND 400 WEST SANDER SHARMA 31. Date filed (Month, Day, Year) FEB 2 32. Paistrar's Signature State 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [11] State
RegistraryFND#26 per MD2/26/08, BMW, MbCo Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** SINGER 3:36 PM ROBERT February 24,2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hopkins The Johns Hospital 8. Date of Birth Jan. 1931 | 9. Birthplace (State of ... Caurdry) | Washington, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 577-38-3256 77 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturet", or items 23s or 28s-1 show any njury or other traumatic event, the Medical Examinar must be conflied at once. 1 Yes 2 No Montgomery Silver Spring Maryland Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20906 3200 N. Leisure World Blvd., #1008 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 Mo If Yes, Give Year or Dates: Korean 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: white 1 ☐ Yes 🗶 No Specify: Saltimore, Maryland 21215-0036 à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sure Fit Elementary/Secondary (0-12) College (1-4or 5+) Auto Business Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Selma Levinson Samuel Singer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3200 N. Leisure World Blvd., #1008, Silver Spring, MD Geraldine Singer, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden 02/26/08 Falls Church, VA 21. Signature of Funera Sarvice Licensee forchings Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METABOLIC ACIDOSIS ISHOCK **Physician** /Medical Due to (or as a consequence of): **Examiner** SHOCK LIVER Esquerdially liet co. ultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ACUTE BENAL FAILURE Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. METASTATIC PANICREATIC CANCER Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1105 Pt TO L 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To efter death.

Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No М 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 24/08 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) BHARAT RATTAN; THE JOHNS HOPKINS HOSDITAL GOD N WOLFE ST BALTIMORE (MO) 21287 32. Bgistrar's Signature 31. Date filed (Month, Day, Year) 26 2008

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State Registrar

31. Date filed (Month, Day, Year) FEB 2 6 2008



d address of person who completed cause of death (Item 23a) (Type, Print)

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			State of Marylar 1 - State Registrar	nd / Department of Health and M Certificate of Death	ental Hygie	2000 01120
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death 3.130A M
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 7. Age (in yrs. 1 M 2 D.F 9 4 Usual Residence of Decedent	last birthday) If Under 1 Year Uf Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
21215-0036	d within 72 hours after death with the Maryland joine. Ir then "naturel", or Itame 23a or 28a-f ehow The Medical Evantrer must be notified at	Completed by Funeral Director	10a. State 10b. County 10c. Ci 10a. Street and Number 10c. Ci 10a. Street and Number 10c. Ci 10b. Street and Number 10c. Ci 10c. Street and Number 10c. Ci 10c.	ty, Town or Location (W. WASh MGT8 n., D.C.) 10f. Zip-Gode 2002 LS. 13. Was Decedent of Hispanic Origin? (Sperify Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of works) [ife. DO NOT use retired]	acify Yes or No- Rican, etc.)	10d. Inside City Limits 1
Baltimore, Maryland 21	1 and 2 should be filer Health and Mental Hyg sm 27 is marked othe ther traumatic event,	To Be Co	2 Burial 2 ☐ Cremation 3 ☐ Removal from State	19b. Mailing Address (Street and Number or Rura 513 Fairhill Drive Silver of Disposition (Name of cemetery, crematory or other place)	o (First, Middle, Maid Bowles al Route Number, Ci ver Sprin Date 200	g, MD 20904 Location - City or Town, State
Baltir	permit. Pages Department of I Important: If it, any injury or o		21. Signifur Funeral Societice is a second of the dear shock, of heart failure. List only one cause on each line.	4001 Benning Road,	ewart Fun NE Washi	eral Home, Inc. ngton, DC 20019
760,	Pnysicient /Medical Examiner the prinal-transit the prinal-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	quence of): Quence of): Quence of):	Disea	
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Division of Vital	or Attending Phyeicien: ifter death. Director: After this certific in by the funeral director.	Certification; To Be C	27. Manner of Death 1 Natural	DER/Outpatient 3 □ DOA Other: 4 Nursing Ho 28b. Time of Injury 4 Work? M 1 □ Yes 2 □ No 1 □ Yes 2 □ No	28d. Describe how	at and Number or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my kn (Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	owledge, death occurred at the time, date and place, ation and/or investigation, in my opinion, death occurred.	red at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year)
2	3 Sta Registr		30. Name and address of person of completed cause death (Ite 2000). 31. Date filed (Month, Day, Year) FEB 2 7 2008	m 23a) (Type, Print)	D Ave S	2/23/08 SE#30700 2002

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 Month **Physician** Year 12:16 2000 ebruary Herman Edwin Swope /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M M 2 □ F Yrs. Director 217-16-2993 84 4/14/1923 Hagerstown Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Nes 2 No Directo MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 Salem Avenue 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed witnent of Health and Mental Hygier tant; If Item 27 is marked other the jury or other traumatic event, the Vehicle Investigator Dept. Motor Vehicle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Edwin Swope Ethel Pauline Shank Swope 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Swope Wife 1213 Salem Ave. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department or Important; If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/28/2008 Hagerstown MD 21. Signature of Funeral Service Lies isee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** one week /Medical Diffale Colitis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tra Due to (or Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 1∏Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl 24 hours after death.Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature ar of certifier 29c. License number lappans Rd Boonston MD 21713 30. Name and address gause of death (Herr-23a) (Typ) 10H-5+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 2

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23 2008 12:03 AM Richard Lee Shubert February 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 218-62-8305 54 1/12/1954 Hagerstown Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 KYes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 11 W. Baltimore Street 21740 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ■ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Bartender Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Shubert Helen Catherine Neal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 Elizabeth St, Judy Hall Sister MD Hagerstown 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Paul Cemetery 2/28/2008 Leitersburg. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Mar 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or compleshock, or heart failure. List only on tions that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLL Due to (or as a contequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequance of) (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760. Division or Vital Records.

attending physician signed by certificate has or Attending Physician: After this s after death. within 24 hours at Hospital

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certification:

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(Check only

30. Name and address

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Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiene.

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Pages 1 and 2 should nent of Health and Men

Item 27

permit. Pages Department of Important: If It any Injury or o once.

Physician

/Medical

Examiner

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be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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State

DHMH 17 Rev 1/2001

Registrar

of person who completed cause of death (Items

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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			1 - State Registrar	0		Ce	rtificate o	of Death			Reg. No.	4000	0//31	
В	Physic	an	Decedent's Name (First, Middle, L.)	ast)						2. Date of D	Death Day	Year	3. Time of Death	
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	Examir	ner	4a. Facility Name (If not institution, gi	3	1.7	1	0 11	n, or Location	of Death		4c. C	ounty of Death		
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	Funeral Director			1□M 2 V F	61	Yrs.	Months Day		Min.	8. Date of E (Month, I Mar 1	Day, Year)	6 Texa	place (State or Foreign intry)	
	AND IN		Usual Residence of Decedent							nai i.	1, 1,74	0 ICAC		
	nylan how		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
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	er de İtemis	nne	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Decedent of If Yes, specify C	of Hispanic Or Cuban, Mexica	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	No- 14	 Race - Amer Black, White 		
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/aii	Ment Ment arked	2	Manuel Silva					Espei	canza	a Sando	oval			
Maryland	2 sho and is ma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Stre	eet and Numb	er or Rur	al Route Num	ber, City or	Town, State, Zi	p Code)	
2	and ealth m 27	1 1	Cynthia Gutierrez	/daughter			Montgom							
o.e	Pages 1 nent of H int: If itel		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 [☐Removal from State	Ce	emetery, crei	sition (Name of matory or other	place) ¦		Date		ation - City or T	•	
Ë	. Pa tmen tant: jury		4 ☐ Donation 5 ☐ Other (Spec		Ches		e Crema			·		ville,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical onge.		21. Signature of Funeral Service Lice	nsee		Gổ	Name and Add	dress of Facili e Crema	tion	n Servi	ice P	.O. Box	784	
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Box	h cer endin use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth	pf pregnar	ncy	7m-44-14-14-14-14				23	d. Date of deliv	very	
	deat e att	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at			Ectopic pregna Other <i>(specify)</i>				Month Day Year			
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	w requires that s been signed t s should be deta	by F	Part II. Other significant conditions			-	nderlying cause	given in Part I		23e. Did		_	the cause of death?	
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	e Ho 24 h e Fui letely	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examinati	ion and/or in	vestigation, in m	ny opinion, dea	ath occur	red at the time	e, date and p	lace, and due	to the cause(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier				29c. Lice	ense number			29d. Date	signed (Month	, Day, Year)	
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21		1	30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print)				_			
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			Od Data Glad Afrach Day March	OO Desirtus	ela Ciarret							,		

DHMH 17 Rev 1/2001

Registrar

FEB 2 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:00 P M 23 2008 Francis John Tacik February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 8120 Canterbury Drive <u>Frederick</u> If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □XM 2 □ F 71 Yrs. **Director** 371-36-9425 July 10, 1936 Pennsylvania Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8120 Canterbury Drive 21704 United States 12. Was Decedent Ever in U.S. Armed Forces? 1954 – 1 Dyes 2 □ No If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Land / Agriculture Surveyor traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental h Important: If item 27 is marked ott any Injury or other traumatic even once. Be Anne Lacovic Emil Tacik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Fairhaven Court, Lewisville, NC 27023 19a, Informant's Name/Relationship (Type, Print) Eric Tacik / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Grandview Cemetery 2/29/2008 Johnstown, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral nome 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Immediate Cause (Final disease or condition resulting in death) **Physician** extensive Small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trai Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 B No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 after death. within 24 hours a

To the Funeral [

10

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 7 2008

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F.A.C.P

4 ☐ Homicide

29b. Signature and title of certifier

Gregory Kausch

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D142 2C

29d. Date signed (Month, Day, Year)

501 West 14th St Frederick, MD 21670

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day DENISE MICHELLE TRUDO 10:23 PM Ebruary 18,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2√ F 220-70-5795 50 Director OCT. 27 1957 MILTON FLORIDA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1920 VERMONT AVENUE 20785 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify BLACK ģ Specify: 3 ☐ Widowed 4 🂢 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th LEGAL INSTRUMENT EXAMINER GOVERNMENT Department of Health and Mental Hygis Important: If item 27 is marked other is any Injury or other traumatic event, <u>tr</u> once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be HOLLIS TRUDO ERMA WALDEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMMA TRUDO/MOTHER 1920 VERMONT AVENUE LANDOVER, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 2/27/2008 BRENTWOOD, MARYLAND permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Ba 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumor /Medical Due to (or as a consequence *) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician s the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) MID 2 19/08 D0062116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7705 Bell WUZKNEH

Registrar

31. Date filed (Month, Day,) FEB 2

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23 2008 Physician Month Pauline B. Thornton 4:00 PM February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 226 36 7154 77 Apr 5, Director 1930 Virginia Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d, Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9352 Rustling Leaf 21045 United States r death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Media Specialist Howard Co. Public Sch. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dudley Thornton Beatrice Doleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Thornton/Daughter 49 E. Mountainview Rd. Queen Creek AZ 85243 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3

☐Removal from State 4 □ Donation 5 □ Other (Specify) Love and Charity Cem. 2-29-2008 | Willwood, VA 21. Sienature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. Gll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wetastanc color concer Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 'es 2 \ certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSA (C 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tyes 2 No 2 🗖 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0051926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles St Baltonore MD 21204 Glorda mo Helen M. 31. Date filed (Month, Day, Year) FEB 2 6 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lois Taglialavore 20, 2008 4c. County of Death /Medical February 13:37 PM 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County E1kton If Under 1 Year Cecil If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
April 26,1943 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In vrs. last birthday) Days 1□M XXF Months 218-40-5931 64 Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In an it if Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a be notified at xry or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sh dical Examiner must be notifled 1 ☐ Yes 2√No Ceci1 Director Maryland North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 65 Schuckler Drive Funeral 21901 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lighting Decorator Retail Lighting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ Edward Lee Long Thelma Louise Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Winifred Corbett / Sister 65 Schuckler Drive, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) February 3 □Removal from State 23, 2008 Maverdale Crematory Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Sign Wire of South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KROM Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner The law requires that the death certificate be executed ens Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has e 2 autopsy performe certificate ha 2 No 1☐ Yes 2 **1**No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 은 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident s after death. 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and
To the Funeral DI 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar filed (Month Day Year) 5 2008 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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	/Medic Examin			vn, or Location of Death		4c. County of D	
		8		Burnie		Anne Ar	
	Funeral Director		5. Social Security Number 219–92–5251 6. Sex 1 Months 1 M		8. Date of Birth (Month, Day, Aug. 20	,1906 9.	Birthplace (State or Foreign Country) China
	Maryland of show fied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Severna Park				10d. Inside City Limits 1 ☐ Yes 2 X No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 128 Clarence Avenue 10f. Zip Coc 211		10	og. Citizen of What	Country?
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7≥	and 2 sealth au n 27 Is ner trau		Lang Vuong/ Daughter 128 Clarence	e Avenue	Severna 1	Park, MD	21146
Fran Lien Baltimore, Maryland 21215-0036	Pages 1 nent of H ant: If Iter ary or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other Glen Haven Memory)	orial Feb	23,	20c. Location - City Glen Burn	nie, MD
Balt	permit. Departr Importa		21. Signature of Funeral Service Linesee 22. Name and Ar Barranco 495 Gov.	ddress of Facility & Sons, P Ritchie H	A. Seven	rna Park rna Park,	Funeral Home MD 21146
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.	dying, such as cardiac	or respiratory arre	est, etin	Approximate Interval Between Onset and Death
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.O. Box	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregn 4 ☐ Pregnant at time of death 5 ☐ Other (specifing the pregnancy)			23d. Date of Month	f delivery Day Year
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o	Phys r this ral dir	<u>۲</u>	Tompatient 2 Gen/Outpatient 3 G BOA		lome 5 ☐ Reside	ence 6 Other (Specify)
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Division or Vital Records,	I or Attend after death. Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, off building, etc. (Specify)	fice	28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 ☐ CertifyIng Physician: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in and manner stated.				
	To th Withir To th	/ Me	29b. Signature and title of certifier Cernsul M. D. 29c. Lie	cense number	1 1	9d. Date signed (A	fonth, Day, Year)
	Took	N	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHWard Steven and CT	-no of	PIK-S	1208	md,
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 21, **Physician** 10:20 A^M February 2008 Theresa Mae Valentine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Medical Center Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F Hours Min. Wash., 06-20-1961 D.C. Director 217-90-6766 46 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Chesapeake Beach MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20732 USA 7343 F Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Specify: þ white 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed home cleaning residential cleaning 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Cohen Charles Kenneth Earp. Ann ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7343 F. Street, Chesapeake Beach, MD 20732 William D. Valentine, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02-26-2008 Alexandria, VA Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 2 100 or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Month, Day Year)

At hor After t 1 Natural 5 Pending investigation accillent austo 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Bural Route Number, City or Town, State) Old Buys, A. Rock, Chemp Eake Heard M 3 ☐ Suicide 28e. Place of injury - At home, farm, building, etc. (Specify) filled in by determined 4 ☐ Homicide street 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) 525 CHUTTON MD Hedreson . Said A Dope 31. Date filed (Month, Day, Year) 32. Registrans Signature State 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#29D Per PHY. State of Maryland / Department of Health and Mental Hygiene For AMEND#29D Per PHY. State 87 No. 1, State Registrar AACO HEALTH DEPT. 2/25/08 CMH Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:10 February 20, 2008 John Ross Vansant /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel 2513 Lyon Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1**X**XM 2□ F **Funeral** Months Maryland 10,1919 88 Aug. Director 219-11-5621 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2 □ No ıral", or items 23a or 28a-f sl I Examiner must be notified Directo Anne Arundel Maryland Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 United States Funeral 2513 Lyon Drive Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

**Types 2 | No | No | 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married Married
3 Widowed 4 Divorced 1940-Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify Specify: White ò 1945 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Experimental Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Knadler Daniel Ross Vansant, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2513 Lyon Drive Annapolis, Maryland 21403 Barbara Vansant / Wife permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Gardens 2/25/2008 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licensee Mich 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dominediale Immediate Cause (Final Physician 13 disease or condition resulting in death) /Medical Due 1 consequence of) Examiner erosc ero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown ON aucer 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an hask N autopsy performed page 51 ulcers a 5 1□ Yes certificate 2 7 10 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl) one funeral director Be Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) Hospital: 3□ DOA 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation death. 2 Accident by the f after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide To the Fundrs and To the Funeral Direct 4 Homicide 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier f 2/21/08

State

Registrar

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31. Date filed (Month Day,

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30. Name and

of death (Item 23a) (Type, Print)

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 24, Month **Physician** Martina Marie Wagner 2008 February 12:13 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ XF 578-24-6354 Aug. 6, Director 88 1919 Wisconsin Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYes 2 TNO Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 3616 Littledale Road 20895 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. $5 \pm$ Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filt thent of Health and Mental Health and the 1st marked oth tant: If Item 27 is marked oth jury or other traumatic even Be August Henry App Katherine Obermaier ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Wagner/ Daughter 1531 Briarcliff Road, Arnold, Maryland 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. Date 29. 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Puneral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901

nter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between onese and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Perforato Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) physician the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed Yes 2 1 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 5 ☐ Pending investigation 1 ☐ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide fs_Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 ho

To the Fune

completely f (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title 37036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) We we Check, Ms 2/6/19 108 Pay Year Registrar's Signature 31. Date filed State

DHMH 17 Rev 1/2001

Registrar

08-0149	14
Cynthia	Williams

nthia Williams	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.									
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year							
edical Examiner	CYNTHIA WILLIAM	S 4b. City, Town, or Location of Death	February 20, 2008 2228 hrs							
	Facility Name (if not institution, give street and number) Southern Maryland Hospital	Clinton	Prince George's							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
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the Maryland a or 28a-f sh tiffed at one Director	MD PRINCE GEORGE'S 1 10e. Street and Number	BRANDYWINE 10f. Zip Code	10g. Citizen of What Country?							
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Baltimore, permit. Pages 1 ar Department of He Important: If ite Injury or other tr	4 Donation 5 Other Specify: RESURE		27/2008 CLINTON, MARYLAND							
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n Tim	30. Name an address of person who complete cause of death (Item 23a)		204							
e(17)		1 Penn Street, Baltimore, MD 21	201							
State Registra		A o								

		1 - For State Registrar	State of	Marylan	nd / Depa <i>Cei</i>		nt of H		and Me	ental Hy	giene Reg. No.	800	07741
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2 short and le m		19a. Informant's Name/Relationship				•						Town, State, 2	Zip Code)
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To the Hospital or Attending Physician: The law requires that the death certificate Swithin 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the niner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the time in, in my of	ne, date <i>a</i> n pinion, dea	ith occurre	nd due to the d at the time	, date and	and manner as place, and due	s stated. e to the cause(s)
o the o the omple	Med	29b. Signature and title of certifier	2110 1112111	or stated.		2	9c. License	number			29d. Date	signed (Mont	th, Day, Year)
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do		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type,	Print)			voger.				
0		Dr. Khalid Waseer				igers	town,	MD	21742				
St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 8 2	008	gistrar's Sign	ACUTE A	bank							

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 22, 2008 **Physician** 10:35 PM Melvin Phibbs Webb /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Frederick Northampton Manor Nursing & Rehab Center Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 12€M 2□F 231-18-5412 83 Yrs. Director July 6, 1924 Virginia Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Heelth end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1⊠XYes 2□No Frederick Maryland Frederick Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number United States 21701 200 East 16th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Bertha Phibbs William Edward Webb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health er Important: If Item 27 is any injury or other trau 606 Prospect Rd. Mt. Airy, MD 21771 Melvin O. Webb 20b. Place of Disposition (Neme of cemetery, crematory or other in 20c. Location - City or Town, State 20a. Method of Disposition Feb. 26 netery, crematory or other place) Restnaven 11 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Frederick, Maryland Memorial Gardens 21. Signature of Funeral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, lest only one cause on each line. Approximate Interval Between Onset end Death 23a. Pert1. Enter the diseese shock, or heart failure. **Physician** Immediate Ceuse (Final/ disease or condition resulting in death) /Medical Examiner Completed by Physician/Medical Examiner The law requires that the death certificate be executed es the bunel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last signed by the ettending physician end be deteched for use as the bunel-tren Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 DYes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 24 No 1 □ Yes 2 □ No 1 L Y63 the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: Medicai Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Dey Year) 5 Pending investigation 1 Naturel 1 Yes 2 No ours efter death. eral Director: A filled in by the fu death. 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical Exam ner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2-23-08 13091 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Tou Houn Avi Frederick sace Zarai MD

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

FEB 2 6

2008

32. Registrer's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month SEPH WATE 065 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth JESTERVILLE AD BIVALVE WICOMILCO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Dey, Yeer) 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 220-32-13 3 Yrs. Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No WICOMICO BIVALVE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? | 12. Was Decedent Ever in U,S. Armed Forces? | 1 Eves 2 | No 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 21814 SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1954 1 ☐ Yes 2 ☐ No. Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SEAFOOD WATERMAN 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES WATER HEDELLA CARTER

SID JESTERVILLE

CEMETERY

22. Name and Address of Facility

MESSICS FUNR

BIVALVE

20b. Place of Disposition (Name of cemetery, crematory or other place)

VANTICOKE

Asc.u D

Due to (or as a consequence of)

Due to (or as a consequence of):

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)

RD BIVALVE MD 3/8/4

Approximate Interval Between Onset and Death

1

3 □ Probably 4 □ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2-18-08 NANTICOKE, MI

AL HOME POBOX 61

MD

permit. Pegas 1 and 2 should be filad within 72 hours after death with the Maryland Department of Haelih and Mental hygiena. Important: if item 27 is marked other than "nature!" or hema 23a or 28a-f show any liqury or other traumatic event, if a Medical Exampler must be notified at bonds. **Physician** /Medical

Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

/Medical

Funeral Director

ģ

Completed

Be (

10e. Stete

MD

19a. Informant's Name/Relationship (Type, Print)

1 Burial 2 □ Cremation 3 □ Removal from State

M

m00416

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

CHETTY WATER

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Examiner ettending physician end for use es tha buriel-trensit

Examiner

signed by tha e certificate has bean si irector, paga 2 should

requires that the deeth certificate be executed vurs efter death.

• seal Director: After this certifice fillad in by the funeral director. Hospital or Attending Physician: To the Hospital within 24 hours e complataly

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No þ 24a. Wes en autopsy performed? Completed 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 sesidence 6 Other (Specify) Certification: To 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner steted. 29b. Signature and title of dertiff 29c. License number 30. Name end eddress of per io completed cause of deeth (Item 23e) (Type, Print) nris Sa ycle

29d. Date signed (Month, Dey, Yeer) 19/08

too E Carroll It

Salishy MD 21801

State Registrar

31. Dete filed (Month, Day, Ye Year) 32. Register's Signeture 2 6 2008

DHMH 16 Rev 6/95

Physician /Medical Examiner

Funeral Director

"natural", or items 23a or 28a-f show clical Examiner must be notified at the Medical and Mental Hygiene. s 1 and 2 should be filed if Health and Mental Hygic tem 27 is marked other other traumatic event, the Pages 1 and 2. ment of Health a sant: If item 27 is jury or other trau

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Department or Important: If any Injury or once,

The law requires that the death certificate be executed use as the burial-tra physician ed by the a detached f signe be d page 2 : After this certifice funeral director, r or Attending Physician: death. With all 24 hours after death.

To the Funeral Director: /

P.O. Box 68760.

or Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 2 0 0 8 Y Month CHARLES HOWARD WALLS MARCH 2 5:39 p^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 611 Augustine Herman Hwy. Elkton Cecil If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1X M 2 □ F 222-20-2212 76 Feb 19 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Cecil 1 ☐ Yes 2 No Director Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Augustine Herman Hwy. 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXYes 2 No 1952
If Yes, Give
Year or Dates: -1954 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sprinkler Fitter Sprinkler Fitting 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Howard Franklin Walls Emma Mae Hurd ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flo Walls (wife) 611 Augustine Herman Hwy. Elkton, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡Burial 2 □ Cremation 3 □ Removal from State Zion Cemetery 3/8/08 Cecilton, MD. 4 Donation 5 Other (Specify) 21. Signature of Fu eral Service 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): RIELNUUSCULUI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of eath 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00053675 Robutle

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

M.D. 111 W. High St. Elkton, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Robert Monteleone,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State		State o	f Marylan		artmen <i>rtificat</i>				ental Hy		-21	08	0.7	71.5
		-	Registrar 1. Decedent's Name	/Firet Middle I	aet)		Ce	lilicat	e oi i	Jeani		2. Date of D	Reg. No	o. 6 \	000	3. Time o	of Dooth
4	Physic	ian	Lorraine	Zucker	,							Month Februa	Da) 3	Year		5 A M
	/Medi		4a. Facility Name (If r			mher)		4h City	Town or	Location	of Death	rebrue	_		of Death	10.2	J A
	Exami	ner	Atrium Vi					Owing			or Douil				more		
142	Funeral	Г	5. Social Security Nu	mber 6.	Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of B	irth	1	9. Birthp	lace (State	or Foreign
п	Director		215-12-28	23	1□M 2XF	8	35 Yrs.	Months	Days	Hours	Min.	ct 19	192	22	Mary	Tand	
	nd >		Usual Residence of D	Decedent 10b. County		100 0	ty, Town or Lo	nation									
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	with a or	ā	4730 Atri		t #265			10f. Zip					USA	illzeri oi	What Cour	uyr	
	ns 23	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.			ispanic Ori	igin? (Spe	cify Yes or N		14. Rad	ce - Americ	an Indian,	
(0	r Iter	Fun	1 ☐ Never Marrie	d 2 Married	Armed Fo	orces? 2 No						cify Yes or N Rican, etc.)			ck, White,		
93	urs a al', o Exam	by	3 X Widowed 4	Divorced	If Yes, Gi Year or D	ve ates:		1 Yes	20 No	Specify:				Specif	^{ly:} Whit	e	
21215-0036	72 hc natu	Completed by	(Specif	15. Decedent's	Education grade completed)		16a. Dece	dent's Usua kind of wo	al Occup	ation	t of worki	10	16b. k	Kind of B	lusiness/Inc	dustry	
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2	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	S	17 Fether's Name (F	Tirot Middle Le	4	·	Edito	r		10 Math	aria Nama	/Fi A ##:- -		gazi			
anc	ntal Hed of	Be	17. Father's Name (F	_	51)							(First, Middle Priedma		n Surnar	me)		
Maryland	hould d Me mark maric	2	19a. Informant's Nan		(Time Print)		10h Maili	ng Addrose	(Street					ar Tawn	Ctoto 7in	Code	
Ma	nd 2 s Ith ar 27 Is 1 trau		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State William Zuckerman/son 504 Pendleton Street Alexandria, VA 223												,		
ē,	s 1 ar f Hea f Hea ftem		20a. Method of Dispo	sition			Place of Dispo	osition (Nar	ne of	ī		ate			- City or To		
9	Page ent o nt: If ry or		1 ☐ Burial 2X 4 ☐ Donation 5				^{cemetery, cre} esapeal				02/25	5/08	Be1	tsvi	11e,	MD	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce.		21. Signature of Fun			/.	G^2	2. Name ar	d Addres	ss of Facili	¥+ior	n Serv	ice	PΩ	. Box	784	
ä	Depa Impo any Ir		Deve	Y FF	test	t. ≥MO12						P.A.					21029
स	C 10 a		23a. Part1. Enter the shock, or heart	e disease, or co	mplications that	caused the deat										Approxima	ate etween
	Physician		Immediate Cause (F disease or condition			EROSCI								SET	HSE!	Onset and	Death
	/Medical		resulting in death)			(or as a conseq						,	•				
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	ec sit	dical Examiner	Sequentially list condificant, leading to immoduse. Enter Underlicause (Disease or inthat initiated events	nediate ying	Due to	(or as a conseq	quence of):										
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	хап	that initiated events resulting in death) La	ıst	c	(or as a conseq	uence of):										
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Вох	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent p	oregnant		tcome pf pregna		_						23d. Da	ate of delive	erv	
	death e atte d for	icia	in the past 12 m 1 ☐ Yes 2 ☐	onths?	4□Preg	birth 2□Feta nant at time of c		⊒Ectopic pi ⊒Other <i>(sp</i>		′					onth	Day	Year
P.0	that the ded by the detached	hys	9 ☐ Unknown		9□Unkr	iown											
	res tha signed I be det	by P	Part II. Other signific				ulting in the u	inderlying c	ause giv	en in Part I	l.	23e. Did	tobacco	use con	tribute to the	ne cause of	death?
Records,	w require been sign	ed	HIRIAC	FIBE	ILLATIO	N						1]Yes 2	2□ No	3 ☐ Prot	ably 4	Miknown
ec C	has be	Completed	- PULMON	ARY	HUPER	TENSIC	N					24a. Wa	s an opsy	24b.	Were auto	psy findings mpletion of	s available
8	The ate h page	E O										per 1□ Yes	formed?_	0	death?	2☑No	cause or
Vital	ician: Th certificate ector, pag	Be	25. Was case referre examiner?	ed to medical							of Death	(Check only	one)			0.55	ester!
J.	Physi this o	은	1 Yes 2 N	6			ER/Outpatie			4 🗀 NU		ne 5□Res				y) Livi	sted ne
ň	ling F After funera	i.i.	27. Manner of Death Natural	5 Pending		of Injury oth, Day Year)	28b. Time of Injury		28c. Injur Worl			28d. Describe	e how inju	ury occu	rred		
Sic	ttend death stor: , the f	cat	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	be 200 Bloom	e of injury - At h	ome form et	M		Yes 2□		206 1	/Ot t -	A (h D		
Division or	after Dire	Certification:	4 Homicide	determine	d build	ing, etc. (Special	fy)	reet, factory	y, onice		-	28f. Location City or To	own, Stat	te)	ber or nura	i noute Nu.	mber,
	spita lours neral		29a. Certifier	Certifying I	Physician: To the	e best of my kno	owledge, deat	th occurred	at the tir	ne, date ar	nd place,	and due to th	e cause(s	s) and m	nanner as s	tated.	
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 one)	☑ Medical Ex	aminer: On the b	pasis of examination of the state of the sta	ation and/or ir	nvestigation	i, in my o	pinion, dea	ath occurr	ed at the time	e, date ar	nd place	, and due t	the cause	(s)
	To th withir To th comp	Me	29b. Signature and ti	tle of certifier	j.			290	c. Licens	e number			29d. Da	ate signe	ed (Month,	Day, Year)	
			Jasi	. دروی	Labor	ami			D 28	1921			91	281	EF.		
(.0	0.2		30. Name and address	ss of person wh	o completed cau	se of death (Iter	n 23a) (Type,	Print)				A	1		-		
6	12	TASNEEM CAKHANI, 2835 SMITH AVE, SUITE 203, BACD MO21209									03,	BAC					

Registrar

State

31. Date filed (Month, Day, Year) FEB 2 6 2008

32. Redistrar's Signature

ROBINS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 3, Day 2008 Physician Kenneth Eugene Zimmerman 9:42 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehabilitation Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jay, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. ^Y1933 1 X M 2 □ F 220-28-4194 75 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 □Yes 2XINo Frederick Frederick ns 23a or 28a-f sh must be notified Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8147 Stone Ridge Drive 21702 U.S.A. 77 Is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Amed Forces?

**XXYes 2 1 953-1955
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes X No <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental Hiem 27 Is marked ott Be Karl W. Zimmerman, Sr. Margaret Messner P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Mrs. Corrine Y. Zimmerman, wife 8147 Stone Ridge Drive, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Mar. 6, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Lic 22. Name and Address of Facility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1∐ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury within 24 hours after users...

To the Funeral Director; After the function of 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

Francis E. Becker, M.D., 300 West Ninth Street, Frederick, MD 21701 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 30496

29d. Date signed (Month, Day, Year)

March 3, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Catherine Adams March 5, 2008 6:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 30, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 78 1929 Director 227-42-4144 May Virginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notifled at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Prince George's Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be It 7520 Surratts Road 20735 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Robert A. Hairston Estelle Flippen P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Artis / Daughter 808 Carrington Lane Eden, NC 27288 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hairston Family Cem. 4-8-08 Cascade, Virginia 21. Signature of Juneral Service L 22. Name and Address of Facility Perry-Spencer Funeral Home 402 Short Avenue Madison, NC 27025 rellun onnes Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ATherescleration Candievanalan /Medical Die to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed bunial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 👿 No Month Vear 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ò signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2**X** No Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident 24 hours ofter death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 6, 2008 D0045365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1170/ livingston Nd & let fort Warlington MD20744 SIDAROUSMO

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day OS Year Month **Physician** ALLISON Harch HERBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest HOSPITAL Kandallstown | FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 05/03/1915 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months **1**X M 2 □ F Yrs. Director 92 214-73-8105 Usual Residence of Decedent West Indies 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at 1 X Yes 2 ☐ No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. by Funeral 5318 Winner Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked oth Be Joseph Allison injury or other traumatic ဥ Rebecca Howell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5318 Winner Avenue, Baltimore, Maryland 21215
ace of Disposition (Name of Date 20c. Location - City or Town, State Fergus Allison / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of h Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2008 | Baltimore, Maryland King Memorial Park 22. Name and Address of Facility The Derrick C. Jones F/H,P.A 21 Signature of Funeral Service censee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myo cardiat 2 Marction **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, leavy leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): P.O. Box 68760, physician attending philor use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | 1√0 Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

To the Hospital or Attending Physician: after death Director: filled in by the within 24 hours a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randallstown, MD 21133 Abdallah Kafrouri 31. Date filed (Month, Day, Year) State

6 ☐ Could not be

determined

Louin

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

32. Resistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March, 08, 2008

Registrar

	For State Registrar	State o	f Marylan		artment of F		-	giene Reg. No.	008	07	749
sician	Decedent's Name (First, Middle,	, Last)					2. Date of Dea		Year	3. Time o	
edical	Emily K.	Abern			4. 65. To	al analisa of Danii	March	6,	2008		P M
miner	4a. Facility Name (If not institution, Greater Balti:	-	,	ter	Towson	r Location of Deatl	n		unty of Deatl Limore	п	
ral		6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl		9. Birtl	hplace (State untry)	or Foreig
or	068-01-4925	1□M 2XF	98	Yrs.			Jan 22	, 1910		nsy1va:	nia
	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside C	City Limits
once. To Be Completed by Funeral Director	Maryland Balt:	imore		Coc	keysville	<u> </u>				1 ☐ Yes	2 ∑ No
Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?	
la	13801 York Road			- Tao		21030		144	USA	dana Indian	
Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Fo		.8. 13.	Was Decedent of H If Yes, specity Cuba	an, Mexican, Puer	to Rican, etc.)	14.	Race - Amer Black, White		
by I	3 X Widowed 4 Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes 2 🖾 No	Specify:		Sp	ecify: Wh	ite	
Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	edent's Usual Occup	ation during most of wo	rkina i	16b. Kind	of Business/I		
협	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			0	e r	
8	12 17. Father's Name (<i>First, Middle, I</i>	01			Homemaker		ne (First, Middle,	Maiden Su	Own I	ноте	
To Be	Henry J.	Kender	dine			Margar	, ,		(inney		
-	19a. Informant's Name/Relationsh			19b. Maili	ing Address (Street					(ip Code)	
	Sarah A. Snyder	r/Daughte	r	_18 W	lendslow I	Road, Lut	herville	, Mar	yland	21093	3
	20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Removal from	1 /	Place of Dispo cemetery, cre	osition (Name of ematory or other plac	ce)	Date	20c. Locat	ion - City or	Town, State	
	4 □ Denation 5 □ Other (Sp				ematory		3/08	Cator	svill	e, Mary	yland
- SOUCE		Larry		$\begin{array}{c c} & L \\ \hline 1 \end{array}$	2. Name and Addre emmon Fur 0 W. Pado	neral Hom onia Road	l, Timoni	um. N	Valle Maryla	y Inc. nd 210	093
	23a. Part1/Enter the disease, or shock, or hear failure. List	only of the confe on e	each line.					rest,	The second	Approxima Interval Be Onset and	etween
n i	Immediate (Final disease or condition resulting in death)	a	MY	OCAR	DIAL IN	FARCT				41 4	112-6
r		Due to	(or as a conse	uence of):	PIAL IN	LATINA				41 r	7.6
Je.	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):	FIBRIC	,,, (00				- 77)	7->-
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
	resulting in death) Last	Due to	(or as a conseq	juence of):							
dical		d									
/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome pf pregna	ancy				23d	I. Date of del	iverv	
iciar	in the past 12 months?	4□Preg	birth 2 ☐ Feta nant at time of d		□Ectopic pregnancy □ Other (specify) _	у			Month	Day	Year
Physician/M	9 Unknown	9□Unkn	nown								
by P	Part II. Other significant condition	ns contributing to d	leath but not res	ulting in the u	underlying cause giv	en in Part I.				the cause of	
ted							1 🗆 \	′es 2□ľ	No 3∏Pr	opably 4	Unknow
Completed							24a. Was		24b. Were au prior to death?	topsy findings completion of	s available cause of
	05 W						1□ Yes	2 No	1 Yes	2 No	
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	or.	ath <i>(Check only o</i>	,	TOther (C	cifu)	
n: To	27. Manner of Death	28a. Date	of Injury	28b. Time o	III 3 DOX	4 LI Nursing F	Home 5 ☐ Resid			uiy)	
ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	nth, Day Year)	Injury		Yes 2 □ No					
Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flace	e of injury - At he ling, etc. <i>(Specil</i>		reet, factory, office		28f. Location (S City or Tox		lumber or Ru	ural Route Nu	mber,
edical Ce	(Check only 2 Medical I	Examiner: On the b	casis of examina	owledge, dea	th occurred at the ti	me, date and plac	e, and due to the urred at the time,	cause(s) ar	nd manner as ace, and due	s stated.	e(S)
Medi	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month										
		1	. 1				T T		3/2/	8	
	30. Name and address of person v	who completed cau	se of death (Item	n 23a) (Tvne	Print)	ockeysu			171	U	
	CYRUS HAMID		13801	YONK	to Co	oc Keysu	LLe, M	1 2	1030		
State	31. Date filed (Month, Day, Year)		Registrar's Signa		K						
	301010 [] [11175 2500	100	45.554	- F						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 🖟

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2008 27 p.m. Ρ. Andrews Maxer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County General Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth : (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Maryland 1 □ M 2 V□ F 73 May 8, 215-30-0317 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Hagerstown Washington Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21742 436 Chartridge Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3altimore, Maryland 21215-0036 à 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co.Schools Cafeteria Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ripley Delia Pindell Joshua ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Thomas Lane Baltimore, Maryland 21219 Mr. Charles L. Andrews, Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/10/08 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Avenue Dundalk, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BAR Physician /Medical Due to (or as a consequence of): 17 Examiner PULMONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner 11 HROM C the burial-trar Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s 1∐ Yes MORAID Division or Vital To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours andthe Funeral Director: A 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40622

Registrar

9286 MERROWWWW OR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Month MAruh **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House CAMEN Hopice Ish stores Aug NESTMINSTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 A F Days Hours Usual Residence of Decedent Director 20/1 90' 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at BAltiMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA AVENUE Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 3 ☐ Widowed 4 Divorced MACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAN RESOURCES Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MA JOSEPH JOHNSON FELME 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Enil Acol Es Fiz inot Pikesville DAUghte WU Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Moodlawn Cenery March 15, Joseph Woodlawn 170 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3436 WEST FURST PAR AVE. Piers Diett Zr. O.A DIGL Boltimore MD 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Physician Yrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): trany leading to hims discause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, for brain lesions 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed Pleural Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1∐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death

Natural

Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Registrar DHMH 17 Rev 1/2001

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State

29b. Signature and title of certifier

NOW

31. Date filed (Month, Day,

Year)

MAR 1 1 2008

29c. License number

D30573

29d. Date signed (Month, Day, Year)

3-10-08

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JANICE ELLEN BRIDGES MARCH 2008 4:30 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death JOSEPH RITCHIE HOSPICE BALTIMORE ear If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2√2 F 220-64-9872 MAR. 15. 1955 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8711 WINDSOR MILL RD. 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH BUS DRIVER TRANSIT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES CAMPBELL MABEL CAMPBELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHAREE F. WILKERSON 50 N 2800 EASTSHIRE DR., BALTIMORE, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1903 HOLLINS FERRY RD. 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) MT. ZION 03/12/2008 BALTIMORE, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disea ey or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur at List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) noma months Due to (or as a conse dence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 9□Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated

Division or Vital Records, P.O. Box 6876

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at

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Certification:

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Maryland 21215-0036

Baltimore,

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital or within 24

> State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

DZ4170

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richey Hospice 838 NEutaw St Baltimore MD

31. Date filed (Month, Day, Year) MAR 1 1 2008 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** BARNETT PRESTON WILLIAM 09:25 AM MARCH 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 236-03-3083 94 Director 22, 1913 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🎘 ☐ No Director Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3505 Georgetown Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethleham Steel Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Barnett Chloe Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores R. Hayes - Niece 3505 Georgetown Rd., Halethorpe, MD 21227 20b. Place of Disposition (Name of Meadowridge) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-10-2008 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park

22. Name and Address of Facility Ambrose Funeral Home, Inc.

23. Name and Address of Facility Ambrose Funeral Home, 21227 Elkridge, MD 21. Signature of Eugeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Kenal disease or condition resulting in death) Acute week /Medical Due to (or as a consequence of): **Examiner** Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine e attending physician and of for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy signed by the atte d be detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES 000

3001 S. HANOYER STREET BALTIMORE, MD 21

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

TARIQ_MAHMOOD

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore.

P.O. Box 68760

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Vital

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MARCH

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. F

Amend Trems- Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 7:50 PM 2000 HEODORE March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Glen Burnie Anne Arundel Moderal Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Min. Hours 216-20-5793 1⊠M 2□F Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director MARYLAND A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 14. Race - American Indian, Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1°K Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No þ 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) GREENWOOD ACRES NURSINGHENE LINKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILDWOOD PARKWAY TOHN BALTO. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory 20a. Method of Disposition TX Burtal 2 X Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) ALTIMORE. 21. Sonature of Funeral Service Li R. FUNERAL HOME 23a. P. (1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or he it failure. List only one cause on each line. Im negiate Cau = (Final di ear e or condition resul ing in death) Physician /Medical Due to (or as a consquence of): Examiner Due to (or as a chase wence of) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2X No 24a. Was an cate has l autopsy perform certificate 1□ Yes Physician: 25. Was case referred to medical examiner? director, To Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Hospital or Attending Natural (Month, Day Yearl 5 Pending investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mn. 8005, 40, 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJEKODUNMI (Curro 2106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 11 2008

Trisha	M	OZELLA Brown				
08-01334		Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are	e Legible.		
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Physician	R	egistrar Decedent's Name (First, Middle,Last)	2. Date	of Death		3. Time of Death
Mical Examine		TVISHA MOZELLA BROWN		h Day uary 16, 2008	Teal	0115 hrs
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3400 block Woodland Avenue Baltimore	1	4c. Co	unty of Death	<u>_</u>
,		S400 block vvoodiarid 7 veride	s. 18. Dat	te of Birth (MM/DD/	_	
Funeral Director	١	Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min	_	RM 19.19	Foreign	ntry) MARVLAND
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any	-	0a. State 10b. County 10c. City, Town or Location		0 -1		10d. Inside City Limits 1 Yes 2 No
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1218 be fill ental H arked	a	RICHARD BROWN KOSE 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	ETT	A Number City	or Town State	Zin Code)
D 27 should and Mal 7 is m?	잍	1 ELLON LEVELLAND	AVE	BAI TO	MA	21207
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	4	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Lo	cation - City or	Town, State
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altin nit. P. sartme sortan	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	BROK	UNJR.	FUNE,	RAL HOME
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other that injury or other traumatic event, the Medici		Jacqueliae 6 Roane 2176 N. FULI	TON	AVE 1.13	A-LTO,	MD 2/2// Approximate Interval
Physician /Medical		23a Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respir	atory arrest, street	, or mount	Between Onset and Death
raminer	ľ	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions.				
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Division of Vital Records, P. and or Attending Physician: The law requires the restler death. an Director: After this certificate has been signed in by the funeral director, page 2 should be d.	ion:	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No	Sub	ject shot		
isio	ficat	2 Accident Investigation Investigation Suicide 6 Could not be Could not be	28f.	Location (Street ar	nd Number or l	Rural Route Number, City
Div nital or nurs aft rral Di	Certification:	4 V Homicide determined (Specify) Vacant Lot		or Town, State) BLK Woodland		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due	to the cause(s) and time, date and pla	d manner as st ce, and due to	ated. the cause(s)
To th To th comp	Medical	2 w Medical Examiner. On the basis of oxamination states. 29b. Signature and title of certifier 29c. License number				fonth, Day, Year)
	2	O.C.M.E.		Feb	ruary 16, 2	008
		30. Name and address of person who completed cause of death (Item 23a)				
3		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201			
S Regis	tate	31. Date filed (Month, Day, Year) MAR 1 1 2008				
DHMH 17 Rev 1/2		OCME ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per ffh / 8877 3-11-08 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 6;39 p. M Robin M. Buckson 2008 /Medical March 7 Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Pikesville Under 1 Year | If Under 24 Hrs. 8324 Streamwood Drive Baltimore Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Date of Birth (Month, Day, Year) Days Months Hours Min. 1□M 🎾 F Director 215-88**-**5446 **-2-1962** MDUsual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the "Modical Extrainar must be notified at Director 1 ☐ Yes 2 🕅 No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8324 Streamwood Drive 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumation. Libari*a*n Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morton Harris Catherine Jameson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Buckson Sr. 8324 Streamwood Drive, Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3-13-08 Woodlawn, MD zz rame and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 21. Signature of an inch 9200 Liberty Road, Randallstown, MD 21133 Ditt. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ung disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter of carriage Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. I been signed by the should be detached ☐Yes 2☐No 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print loopo.LD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 5, 2008 **Physician** 10:31 March Albert James Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City Johns Hopkins Bayview Medical Ctr. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 ☑ M 2 ☐ F 73 Sept. 16,1934 Maryland Director 214-30-6012 Usual Residence of Decedent I and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. In 27 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 X No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 3321 Belsford Court Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Steel Industry 2 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Mizejewski Albert O. Brown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3321 Belsford Ct. Baltimore, Maryland 21222 Geraldine Brown Health item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 3-12-2008 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final ear **Physician** 7160 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed inding physician and use as the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autops; perform page 2 1∐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death After Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 21202 301 St. Paul Place Rm. 409 Baltimore, MD

State

DHMH 17 Rev 1/2001

Chi-Shiang Chen, M.D.

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month March 5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE RANDALIS TOWN AT Northwest Hospita SEASONS HOSPICE If Under 1 Year 8. Date of Birth (Month, Day, Year) 2/20/1926 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ☑ F 82 **Director** Virginia 229-18-9803 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ant; If Item 27 Is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 2010 Paulette Road Apt. 104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: ð 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Bookkeeper Paper Recycling Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward James Smith Kendall Elizabeth Johnstone ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 895 Raccoon Creek Road Branchland, WV 25506 Ms. Victoria L. Kenny 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 3/8/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Pan Pa 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Viseas-e Physician Chronic Obstructi Ulmonary /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed after death. as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician the double by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the a should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performe certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

M.D.

30. Name and address of person who comp

29b. Signature and title of pertifier

Betty Wang,

31. Date filed (Month

West Coldspring Lane

eted cause of death (Item 23a) (Type, Print)

222

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary and Department of Mealth and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:25 AM J. Buck MARCH Stacev 80 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, NOV 22 Birthplace (State or Foreign Country) 5. Social Security 7283 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 □ M 2 🕮 F MD 220-52-7203 Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fixen Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location 1 ☐ Yes 2 🔀 No Director Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 182 Lake Shore Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cooper Α. Catherine Webb Long ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William A. Buck (spouse) 182 Lake Shore Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Pasadena, Maryland 4 Donation 5 Other (Specity) Mt. Carmel Church Cemi. 21. Signature of Fundal Sen Stallings Funeral Home, P.A. 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) VEARS METASTATIC Physician BREAST CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liease or injury) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 920347 MARCH, 08, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 BALTIMORE MD 21229 AVENUE CATON State

Registrar

BUCK, STACEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01850 State of Maryland / Department of Health and Mental Hygiene William Morris Bowers, Jr Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Yea 1115 hrs March 5, 2008 Medical Examiner Bowers Jr. Morris William 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie 7871 Ritchie Highway 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min Director 214-04-7110 05/07/1966 MD 1 X M 2 F 41 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No Glen Burnie or items 23a or 28a-f shomust be notified at once. Maryland Anne Arundel 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 7178 Ritchie Hwy 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify White Yes 2 X No specify: Yes. Give Year 3 Widowed 4 X Divorced item 27 is marked other than "natural", of traumatic event, the Medical Examiner è 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Anne Arundel Co. Baltimore, MD 21215-0036 iit. Pages I and 2 should be filed within 7 arment of Health and Mental Hygiene. ortant: If item 27 is marked other thau ry or other traumatic event, the Medica Public Schools Assistant Principal 12 4+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Grant Bowers William Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William M. Bowers Sr. 2105 Creekwood Run, Lakeland, (father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, March Date 20a. Method of Disposition crematory or other place) Removal from State 1 X Burial 2 Cremation 3 2008 Ridgely, Maryland Gertrudes Cemeter 4 Donation 5 Other Specify ame and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road, Pasadena, MD 21122 P.A. 21. Sign ture of Fugeral Service Licensee 22. Name and Address of Facility used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Pontine Hemorrhage Due To Hypertensive** Approximate Interval 23a. Part I. Enter the disease, or complications to at a failure. List only one cause on each line. Physician Between Onset and Death 'Medical Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last Physician/Medical X UNPENDED 23a, 27 per me g877 3-21-08 vt Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE: 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? 2 No Yes 2 1 🗸 Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be examiner? Residence 6 Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 V Yes 28d Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME March 6, 2008 OCME. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Month Day, State 2008 Registra

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Block harles ۵ 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medica N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/24/1948 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-48-1182 59 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 No Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or? 4 PEMBERLY LANE 21136 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐X No WHITE Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CATERING MANAGER CATERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **LEONARD BLOCK** ETHEL **FADEM** ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONNIE BLOCK / WIFE 4 PEMBERLY LANE. REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any Injury or ot once. CEMPTAL PARK MEMORIAL PARK 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/09/2008 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AVCEC Vairs UVVC resulting in death) /Medical Due to (or as sequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

0

State Registrar

31. Date filed (Month, Day, Year) MAR 1 1 2008

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) Pau

MD

MD 21202

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0063066

Ryan McCormack, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7, 2008 Year **Physician** MARCH MARGARET V. BLUM 6:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8032 EASTDALE RD EASTPOINT 8. Date of Birth (Month, Day, Year) JULY 22,1927 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. WEST VIRGINIA 80 578-36-0315 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show be notified at 1 ☐ Yes 2 No Director MD EASTPOINT BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō 21224 8032 EASTDALE RD USA 7 is marked other than "natural", or items 23st traumatic event, the Medical Examiner must or items 23a 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No WHITE Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ FREDERICK GRAY FLORENCE DILLOW 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau BALTIMORE, MD 21224 STEPHANIE BLUM-DAUGHTER 8032 EASTDALE ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State OAKLAWN 3/12/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Lice 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Part1. Enter the disease shock, or heart failure periodions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** comcer una /Medical Due to (or as a co sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P 1 ☐ Inpatient 5 Residence 6 □Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

onel

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, MAR 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sig

MD

DOUGLAS

1 2008

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1041968

7602 Belair Rd.

29d. Date signed (Month, Day, Year)

Battimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7**,** 2008 \mathbf{A}^{M} Breitenbach March 1:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 ₹ M 2 □ F 88 29, 1919 Maryland 212-18-7997 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2 录No Directo Maryland Baltimore Glen Arm 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21057 11630 Glen Arm Road Apt. 115 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher School School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Breitenbach Ida Baker Frederick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jarrettsville MD21084 _332_ Stephen Breitenbach/Son P.O. Box 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 03/10/2008 4 □ Donation 5 □ Other (Specify) Baltimore Metro Crematory 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road Baltimore MD 21206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or o shock, or heart failure ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e.g. e on each line. Immediate Cause (Firm CHRONIC DESTRUCTIVE PULMONARY disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe

Physician /Medical Examiner

physician and stran

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Funeral

Director

ral", or items 23a or 28a-f show Examiner ⊓ust be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

the M

7 is marked other traumatic event, the

Department of Important: If any injury or once. = 5

Baltimore, Maryland 21215-0036

2 No 1∐ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation FEBILARY 27, 2008 6 Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury UNFNOWNM

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HUSPICE 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred TRIP AND FALL

28f. Location (Street and Number or Rural Route Number, City or Town, State) 11630 GLENARM ROAD, GLENARM, MD

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D64395 29d. Date signed (Month, Day, Year) MARCH 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MA 6565 N CHAPLES SI, SUITE 209 BALTIMORE, MA 21204 2008

State Registrar

Be (

Certification: To

Medical

filled in by the f

within 24 hours a

To the Funeral I

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 0705AM VONALD COPELAND MARCH 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS BALTIMONE Moder 1 Year If Under Days Hours HOPKINS HOSPITAL 8. Date of Birth (Month, Day, Year) Under 24 Hrs 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral 1**X M 2 □ F 59 JUNE 4, Director 212-46-7848 1948 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XIYes 2 □ No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death v 1734 E. PRESTON ST. 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🔀 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH PLUMBER DISABLE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evance. HARLEY COPELAND **QUEENIE LITTLE** ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1644 NORMAL AVE., BALTIMORE, MD 21213 GERINA COPELAND/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5712 O DONNELL ST. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/15/2008 BALTIMORE, MD 21224 21. Signature of Funeral Service License 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. complications the shock, or heart failure List only Immediate Cause (Final disease or condition resulting in death) Physician resumed /Medical Due to (or as a consequence of): **Examiner** unmous CELL CHRCINOMA OF THE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar The faw requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Q∏ I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1□ Yes 2 PHNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) P20654 mi

State Registrar ZESHAN RAIPUT.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS

2008

HESTITALI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:02 P M 29 08 2 William . Edward Crayton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 XM 2 F 10 - 26 - 31Director Virginia 231-36-6049 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State ir then "natural", or itema 23a or 28a-f ehow Tre Medical Exeminal must be redified at 1 Yes 2 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 639 Kensington Place 20011 USA death 1 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Amed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: If Yes, Give Year or Dates: 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Bureau of Engraving Elementary/Secondary (0-12) College (1-4or 5+) other then Federal Government Forklift Operator 9 7 is marked othe traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Effie Edmonds Joseph Crayton, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 l Gloria Ann Thomas/Daughter 639 Kensington Place, Washington, DC Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place
Mt. Level Baptist 20a. Method of Disposition Department of H Important: If its eny injury or ot once. 1
Burial 2 □ Cremation 3 □ Removal from State Amelia, VA 23002 4 □Dopation 5 □ Other (Specify) 3-5-08 Cemetery 22. Name and Address of Facility V.Y. Scott Funeral Home 21. Signature of Furieral Service Licenses 12020 Bevils Bridge Rd., Amelia, VA 23002 ennu Manne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or Examiner Melnony Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death P.O. I 9 Unknown 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes certificate 2 No Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No ħis 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death After 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number fla in MANNI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dwayne Thompson, M.D. 7600 Carroll Ave., Takoma Park, MD 20012 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Quinton L. Croomer 750 AM March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 216-74-1434 1 M 2 □ F Months Days Hours Director 12-16-1958 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1√Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 914 McKewin Avenue 21218 Funeral 5 A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Black 9 3 ☐ Widowed 4 ☐ Divorced item 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hygiene. The marked other than "no N/A Elementary/Secondary (0-12) College (1-4or 5+) 10th grade N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Croomer Mary Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an item 27 is Mary Vaughan - Mother 914 McKewin Avenue Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD National Mem 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-7-2008 Laurel, MD 21. Signature of Funeral Service Licensee March F/H East 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 Wrette 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kaposi Sarcoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury) Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No certificate Division or Vital 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA this : After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Injury 1 XNatural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funera Director: A completely filler in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 1 1 2008

Samip Patel

29b. Signature and title of certifier

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

193230 2551

Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 1,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	,	Cer	tificate of I	Death		Reg. No.	2008	0//69		
	Physicia	an	1. Decedent's Name (First, Middle, Last) Rose Marie Calafione	2. Date of Death Month Day Year March 6 2008 3. Time of Death									
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or	March 6, 200		4c. County of Death				
			Dakota Assisted Livi			Aberdeen If Under 1 Year	If Under 24 Hrs.	9 Date of Di		ford County			
ı	Funeral Director	200	5. Social Security Number 6. Sex 216-32-3404	7. Age (In yrs. 93	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da April 7	1914 1914	9. Birt Co Mary	hplace (State or Foreign untry) yland		
ryland	how		10a. State 10b. County		y, Town or Loc	ation					10d. Inside City Limits		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	8a-f s	Director	Maryland Harford Co	ounty Bel	Air	T				1 ☐ Yes 2 XNo			
		1909 Emmorton Road #			10f. Zip Code 21015			Unite	en of What Co				
	ral", or Items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	ecify Yes or No Rican, etc.))- 1	4. Race - Ame Black, Whit Specify: Whit	e, etc.			
	ne. nan "natu Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			O NOT use retired	during most of work	ing		d of Business/	Industry		
illed w	Hygier ther the		1 2 17. Father's Name (<i>First, Middle, Last</i>)	Ň/A	Home M	aker	18. Mother's Name	e (First. Middle	Own :				
uld be	nental rked o tic eve	To Be	Vincent Alfonsi				Teresa Bar		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Jaman J			
Pages 1 and 2 shou fent of Health and M nt: If Item 27 Is mar iny or other traumating.		19a. Informant's Name/Relationship (Type Mrs. Teresa Grimes (al Route Number, City or Town, State, Zi a, Maryland 21085			Zip Code)			
	nent of He ant: If Item ary or oth		20a. Method of Disposition 1 Purial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	cemetery, crem	ition (Name of atory or other place orial Garde	ce) ;	Date 10, 2008		cation - City or			
permit.	Departr Importa any Inju		21. Signature of Funeral Service License	ee ·	Eva 3 N	Name and Address ns Funeral ewport Driv	s of Facility Chapel & C ve, Forest	remation Hill, Man	Servi	ces - Be. 21050	l Air		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.							Approximate Interval Between Onset and Death		
	nysician Medical		Immediate Cause (Final disease or condition resulting in death) a. Altherness Denentia 5 years 1 year										
	xaminer		Due to (or as a consequence of):										
cuted	ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):								
rificate be executed	physician and s the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a conseq	uence of):			-					
ertifica	D &		IF FEMALE:	3c. If yes, outcome pf pregna		· ····							
The law requires that the death ce	by the attendir tached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ②▼No 9 □ Unknown	Ectopic pregnancy Other (specify)									
s that t	igned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions								the cause of death?		
equire	been sig should b										No 3 Probably 4 Unknown		
The law r	ate has be	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2€\[No \] 24b. Were eutopsy findings av prior to completion of cau death? 1 ☐ Yes 2 ☐ No			completion of cause of					
		Be C	25. Was case referred to medical examiner?				26. Place of Deat			I I I I ES			
Physi	rthis c	2	1 Yes 2 No H	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient		4 LI Nursing Ho			Other (Spe	city) Living		
ndlng	ath. r: After re fune	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injur Worl	Yes 2 □ No	28d. Describe how injury occurred					
tal or Attending Physician:	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specif		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
the Hospital	in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.										
Tot	To 1	Σ	29b. Signature and title of contifier Perf Chill		29c. License number			29d. Date signed (Month, Day, Year)					
	0		30. Name and address of person who con Prashart Shukla		1 23a) (Type, F	Stref	#400 A	berdeer	mo	2100	1		
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ature	harts)							
	Registr		MAR 1 1 2	UUD Johns	AT A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Cobert Samantha March 2009 4:58 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS Hospital Baltmore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea Oct. 10, 1 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗶 F Germany Ĩ989 Director 216-33-9039 18 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3819 Copper Beech Drive Funeral 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeffrey Dale Cobert Cheryl Ann Brendel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Copper Beech Drive, Abingdon, Maryland 21009
tion (Name of Date 20c. Location - City or Town, State Jeff Cobert / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Park 3-13-08 Baltimore, Maryland ²² Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List onlywone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Kespiratory 13 days DOXIC disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Syndrama 45 days Respiratory DISTURS Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and / Due to (or as a consequence of) attending physician a for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month P.O. 1 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by Graft Versus Host Disease 2 No 3 Probably 4 Unknown 1 🗌 Yes Acute Lymphobolashe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? this certificate 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1/ Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Il Schwark H March 8 2008 anu HD 0060692 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Schwartz 600 N WOIFE St saltmore MD 21287 Jamic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 MAR 1 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Cundiff **Physician** James Roy Jr. March 2008 6:33 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Nursing Gilchrist Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months XXM 2 I 59 217-50-8137 12-19-1948 North Carolina Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notifiled at Harford Pylesville 1 □Yes 2 X No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2041 Neal Road 21132 U.S.A. by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2【 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🍇 📆 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 12 Department of Health and Mental Hygis in portant: If item 27 is marked other i ar y injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be James Cundiff Sr. Minnie Britt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joann Cundiff 2041 Neal Road Pylesville MD 21132 Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 3-11-2008 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk Inc 21. Signature of Funeral Service Licenses 7922 Wise Avenue Dundalk MD 2/222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death for Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably **♦**Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe Yes 2 has this certificate Yes Hospital or Attending Physician: 26 Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200,No 1 ☐ Yes 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient funeral Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25643 who completed cause of death (Item 23a) (Type, Print) W. Tousantown . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12;30DM Doris E. Cartwright /Medical 03-03-2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Clinton Southern Maryland Hospital 5. Social Security Number 6. Sex 7-Age (In)rs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖫 F Director 135-22-8173 10-8-1929 N.J. 10a, State 10c. City, Town or Location 10d. Inside City Limits 10h County or 28a-f show e notified at show Yes 2 No Director Fort Washington MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ral", or items 23a or Examiner must be r USA 20744 Funeral 8212 Joselle Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black by If Yes, Give Year or Dates: Specify 3 Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiens in Inportant: If Item 27 is marked other than "naturany Injury or other traumatic event, the Midical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Seamstress 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ၉ Edward Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joselle Ct. Ft. Washington, MD 20744 Teresa Williams/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD. Veterans Ceme: 3-12-2008 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ronald Taylor II FuneralHm 108 W. North Ave. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed bunal-tran Due to (or as a consequence of) ivision or Vital Records, P.O. Box 68760 physician Physician/Medical the 1 SB IF FEMALE nse s If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day for in the past 12 months? 1 ☐ Yes 2 2 No Month Year the detached 9 Unknown 9 ☐ Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate ha 1□ Yes 2 XNo funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Denatient 2 ER/Outpatient 3□ DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending Pl 4 hours after death. Funeral Director: After ti rely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred After t Injury at Work? Certification: Netural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Funeral 29a. Certifier 15-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

Registrar

State

TIZ)

30. Name and addr s of page in who completed cause of death (Item 23a) (Type, Print)

MAR 1 1 2008

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 6, 2008 8:00AM Lawrence Joseph Cain /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda
If Under 1 Year | If Under 24 Hrs. Montgomery Suburban Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ X/1 2 □ F Yrs. August 28, 1918 Massachusetts Director 89 578-16-0236 Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at 1 X Yes 2 □ No Directo Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a 20878 United States 11716 Fernshire Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3X Widowed 4 □ Divorced White WWII Completed 16a Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Labor Union Executive 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 1 and 2 should be Caroline Lynch Lawrence P. Cain 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 11716 Fernshire Road, Gaithersburg, Maryland 20878 Lawrence Joseph Cain, Jr./Son Saltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 10, 2008 4 □ Donation 5 □ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Severe Sepsis /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any leading to firm hediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician law requires that the death certificate be Physician/Medical the as 1 IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown n signed by th. 1 be de⁴ 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The 4 hours after death. performed? 1□ Yes 2X No certificate director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 29c. License number

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Registrar

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Shahryar Davair, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

Date filed (Month, Day, Year)

32. Registration Signature

MAR 1 1 2008

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 11

2008

31. Date filed (Month, Day, Year)

State

Registrar

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

283 32. Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Smith Avenue Svite 203

29d. Date signed (Month, Day, Year)

March 5th 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., 1887, Department of Health and Mental Hygiene Certificate of Death Reg, No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year ADALINE M. CREASY MARCH 2008 8:25A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8100 Rossville Blvd. Room 205 Baltimore County Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√√ Yrs. Director 218-07-2776 93 Aug. 26,1914 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 217 No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 8100 Rossville Blvd. USA Room 205 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🗶 🛛 No Specify: Specify: White Baltimore, Maryland 21215-0036 ¾Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Wescott or other traumatic ပ <u>Mary Eisenberg</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 9912 Pepper Hill Rd. Perry Hall, Md. 21128 Barry Creasy (Step~son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Immanuel Luth. Ch.Cem. 3⊸7⊸08 21. Son tur of Funeral Service Lice se 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertesion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perforn certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: △ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item of Maryland Department of Health and Mental Hygiene

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			Amend #1, perMD,g877 3/11/08 TT Certificate of Deat	th	Reg. N	o.	01110				
			1. Decedent's Name (First, Middle, Last)		e of Death	av Year	3. Time of Death				
	Physicia /Medic		Daly, Jean Jean Marie Daly	Mar			11:30 AM				
-	Examin		4a Facility Name (If not institution, give street and number) 4b. City,	c. County of Death							
-			Crofton Care & Rehabilitation Center Croft		Aı	nne Arui					
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Nonths Days Hours	rs Min. (Mo	e of Birth onth, Day, Year 15/1911		nthplace (State or Foreign ountry)				
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	the M	ect	MD Anne Arundel Davidsonv 10e. Street and Number 10f. Zip Code	ville	10a C	itizen of What C	ountry?				
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	as cardiac or respir	ratory arrest,		Approximate Interval Between Onset and Death				
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o u	ng Ph fter th ineral	ä	27. Manner of Death 1		escribe how inj	ury occurred					
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Division of Vital	or Att	Ē	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		cation (Street a y or Town, Sta		Rural Route Number,				
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	To the Hospital or Attanding Physicien: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification:	(Check only one) Check only one)								
	To the within 2 To the comple	_	29b. Signature and title of certifier 29c. License number	per	29d. D	ate signed (Mor	signed (Month, Day, Year)				
	1		Makesharona MD DZ	0108		3/6	108				
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA, MD 14300GALLANTFOX	x LN#2	22,130	WIEM	020715				
	Stat Registra	e	31. Date filed (Month, Day, Year) MAR 1 1 2008 32 Tegistrar's Signature	,							

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 8:45 PMM February 27 2008 Duszynski /Medical Sharon Maria 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4412 Payne Drive Ft. Washington Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 6. Sex Months 1 M 2 XF Director 02/06/1950 MD 58 214-54-2558 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show at 1 □Yes 21X No be notified Director Ft. Washington MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 Items 23a must ! Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Then to T Is marked other than "natural", or items 23 and: If Hean 27 Is marked other than "natural", or other traumatic event, the Medical Examiner must uny or other traumatic event, the Medical Examiner must by Funeral 20744 4412 Payne Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married **Baltimore**, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Convenience Store Clerk 12 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kolasinski Regina မ Andrew Markiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4412 Payne Drive Ft. Washington, MD. 20744 Robert Duszynski (husband) 2 Cremation 3 Removal from State

10 5 Other (Specify) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 🔀 Burial Rosary Cemetery 3/3/200d Dundalk, MD. 22. Name and Address of Facility Duda-Ruck Funeral Home Of 21. Sign, ure of 10 Dundalk, Inc 7922 Wise Ave. Dundalk, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Matastatic disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has e 2 2 ☐ No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8 08 30. Name and divress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Pay State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8, 2008 11:58 PM Edith Koiner Dempsey March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F 216-44-4348 91 Director June 8, 1916 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4890 Battery Lane, Apt. 315 20814 United States Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 , or 1 ☐ Yes 2 No Specify. Specify: White þ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other ths any injury or other traumatic event, the once. Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garnett Koiner Mary Catherine Scherrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Lanier / Sister 4890 Battery Lane, Apt. 423, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 14, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 2008 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda- Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01305 annie 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1 Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Failure Physician Weeks disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner Acute Myocardial Infarction Weeks Sequentially list conditions, if any, leading to himmidat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in examination and/or investigation in examination. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title Certifier 29c. License number 29d. Date signed (Month, Day, Year) March 10, 2008 D33357 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee Jonathan Musher, 5530 Wisconsin Avenue, #1045, Chevy Chase, Maryland 20815 M.D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30 AM **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2X 92 Yrs Director 213-01-7479 June 14, 1915 Denmark Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "netural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. Baltimore Parkville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. Apt. 2022 21234 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No ≥ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schoeneman's Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Margrethe Geckel Fritz K. Berndt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 234 19a. Informant's Name/Relationship (Type. Print) John Edelmann/Husband 8810 Walther Blvd. Apt.2022 Parkville, MD. Department of Heal Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State Peges 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/08/08 Forest Hill, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License permit. Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): physician s the burial Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancel 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: Hospital or Attending 24 hours after death, se Funeral Director: A sletely filled in by the fu within 24 ho

To the Function

completely 1

Baltimore, Maryland 21215-003

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29b. Signatore and title of certified

MAR 1

and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7, 12:35P M March 2008 Bernice Ann Entz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Co. Riverview Nursing Home Essex If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 ☑ F 14,1933 Director 74 202-24-6574 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director \mathtt{MD} Baltimore Dundalk 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Funeral 7320 Kirtley Road S A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sorter **Pharmaceuticals** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Matiaucks Anna Skodis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Gencel 7320 Kirtley Road Baltimore MD 2]224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 03-11-2008 Baltimore MD 22. Name and Address of Fecility Duda-Ruck FH of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ept 1 Ce Mia Physician Two weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Tract Infection **Examiner** Iwo weeks Urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dementia or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2MNo 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P0061907 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1124 Mace Ave. Essex, Maryland Chukwuma Ebo, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 11

2008

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** THOMAS **ESTES** 00:24 M ਿੰ 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex 1 **X** M 2 □ F 8. Date of Birth Birthplace (State or Foreign Country)
 MD Funeral 0471871936 Days Months Hours Min. 71 MD 263-46-9381 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 21208 USA 14 BRETON HILL ROAD, APT. 1A Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or Items 233 any injury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DESIGNER ADT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YOUNG **ESTES** NOREEN ۵ RICHARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 BRETON HILL ROAD, APT. 1A, BALTIMORE, MD 21208 ANN ESTES / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State CARROLL CREMATION INC 03/10/2008 HAMPSTEAD, MD 4 Donation 5 Dother (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Juneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMPHYSE MA **Physician** disease or condition resulting in death) 10 years /Medical Due to (or as a consequence of): Examine LYMPHOMA 10 years FOLLICULAR Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Physician/Medical attending ph I for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day i signed by the a ld be detached fo 5 Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page performe certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, D 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD AT-2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Union Memorial Carmen 31. Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Michael Stephen Ference 12:30 A^M 2008 March 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year)
Ian. 15, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F 181-16-6303 86 Director 1922 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified 1 X Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 Grosvenor Lane 20814 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1942 – Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Ĩ942 1945 1 ☐ Yes 2 🔀 No Specify <u>\$</u> Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter Stee1 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ference Anna Evans ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 S. 17th St., Lewisburg, PA 17837 Delores A. Komlos (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ascension Cemetery 3/12/08 4 Donation 5 Dother (Specify) Clairton, PA 22. Name and Address of Facility
Stephen D. Slater Funeral Home
1701 State Route 51, Jefferson Hills, PA 15025 21. Signature of Funeral Service Licensee 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** ATRIAL FIBRILLATION Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Ö the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed? Yes 2 XI No certificate Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 27. Magner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director: After (Month, Day Year) Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-27660 30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

Alpana Goswami, M.D. 11119 Rockvill 11119 Rockville Pike Gl00 Rockville, MD 20852

State

Registrar

31. Date filed (Month, Day, Year)

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FERENCE

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** les larch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BaltimorE 1 Year | If Under 24 Hrs. (omm. If Under 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) last birthday) **Funeral** Months Days Hours Min Mary land 1 M 2 □ F 217-18-2000 Yrs. Director Usual Residence of Deceden should be filed within 72 hours after death with the Maryland nd Mental Hyglene.

marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Towson Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 615 Chestnut Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Plumber 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofthe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Charles T. Fishpaugh, Sr. Mary C. Fishpaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Fishpaugh / Brother 1114 Sturbridge Rd. Fallston, MD. 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 03/10/08 Catonsville, MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Evans Funeral Chapel & Case of the state of 8800 Harford Rd. Parkville, MD. <u>21234</u> Approximate Interval Between Onset and Death mon PhS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March, 7, 2008 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 6565 North Charles ST, Suite 209, Towson MD 21204 Jason Black MB 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item :20b per F.H. C-877 3/11/08 reb
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Wanda Μ, trauke 15:49 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

Baltimore

If Under 24 Hrs. University of Maryland Medical 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2X F 84 1071571923 308-20-9845 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Anne Arundel Fort Meade 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or important; in Item 27 Is marked other than "natural", or items 23a or in yilury or other traumatic event, the Medical Examiner must be a 2588 Washington Avenue 20755 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates 1944-1945 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Packer Manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ William Brown Dora Medcalf ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Truszkowski / Daughter 625 Chestnut Street, Williamstown, NJ 08094 20b. Place of Disposition (Name of cometery, crematory or other place)

Broderhood Cemetery
Brotherhood Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Williamstown, NJ 3/12/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (ardiops/monage arr Est /Medical Due to (or as a conseque ce of): Examiner schemic brain injury Sequentially list condulors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): withdraw Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Danielle Dabbs 22 S. Greene Street Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 11 2008 ALL WELL Registrar

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: s after death in by within 24 hours aft

To the Funeral D

completely filled in

altimore, Maryland 21215-0036

20

To the I

Medical

(Check only one)

31. Date filed (Month. Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie

29b. Signature and title of certifier

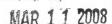
29c. License number

29d. Date signed (Month, Day, Year) D53367 March 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Avenue #1-17, Silver Spring, Maryland 20902 Shyamsundar Rajan, M.D.

Registrar





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend item19b per fh e8/7 3-11-08 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 03 92Z A 0 7 2008 HAM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN Square HospiTAL Rosedale Baltimore Center 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min 212-20-335 Usual Residence of Decedent 1923 Baltimore MC Director 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show a or 28a-f show be notified at 1 ☐ Yes 2 No Director MD Da arne timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Important: If Item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must b 21234 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after eafth and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced whit Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemakei + 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) husband 8800 was the 20th Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is MD 21234 Michae 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 □ Cremation Removal from State 11/08 Baltimore, MD 4 Donation 5 Dother (Specify) 10 8800 Harford In , BACTI MOEGNOZIZBY 21. Signature of Funeral Service Ligensee pel-Cremation Services-Parkville Evans Funcra Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Immediate Cause (Final a. Mrocerebral and **Physician** disease or condition resulting in death) Intraventricular hemorrhage /Medical Due to (or as a consequence of) Examiner hyperTension Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed2 this certificate 2 No 1□ Yes or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after To the Hospital within 24 hours a [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jano D0056092 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 FRANK UN Square md 21237 DR Baltimore DR Edana D Mann 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

Physician /Medical Examiner

Funeral Director

		State of			artment of F			•		egible.		-10
1	For State Registrar			-	rtificate of			R	eg. No.	2008	U/	18
1	Decedent's Name (First, Middle,	, Last)			GRIN	AGE		Date of Deal Month ARCH	Day	Year		of Death
4	a. Facility Name (If not institution,	_			4b. City, Town, o				4c. 0	County of Deatl	1	
	JOHNS HOPKINS	BAYVIEW	MEDICAL	CENTER	If Under 1 Year	Time!		Data of Blate		N/A	(Ot-to	
Г	Social Security Number 215-52-0918	6. Sex 1 ∑ M 2 □ F	7. Age (<i>I</i> n <i>yrs</i> . 1	8 Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day R. 17	Year)	Cot	nplace <i>(State</i> un <i>try)</i> YLAND	e or Foreig
⊢	Usual Residence of Decedent Oa. State 10b. County		10c. City	y, Town or Lo	eation	·····					10d. Inside	City Limits
	MARYLAND BALTIMORE BALTIMORE											es 2 🗓 No
1	0e. Street and Number				10f. Zip Code	<u> </u>		1	0g. Citiz	en of What Co	untry?	
L	860 MAPLECRES		2122					.S.A.	in a tadian			
1	Marital Status Never Married 2 Marrie	Armed For		S. 13.	Was Decedent of F If Yes, specify Cub	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)				Black, White		
	3 Widowed 4 Divorced	If Yes, Give Year or Da	e		1□Yes 2⊠ No	Specify:				Specify: BLACK		
F	15. Decedent' (Specify only highest	s Education t grade completed)		(Give	dent's Usual Occup	durina most	of working	- 1	16b. Kin	d of Business/I	ndustry	
-	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use retire	d) -				RGINIA		
-	llth grade 17. Father's Name (<i>First, Middle, L</i>	Last)		RET	TIRED DIS		's Name (Fi	rst, Middle, i	TRANSPORTATION e, Maiden Surname)			N
	ALBERT HALL	•						RINAGI		•		
	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Maili	ng Address (Street						ip Code)	
	Beatrice Grina	ge/Wife			Maplecre	st Dr.		timore				
2	20a. Method of Disposition 1XXBurial 2 ☐ Cremation	3 ☐Removal from S		Place of Dispo emetery, cre	osition (Name of matory or other pla	ce)	Date		20c. Loc	cation - City or	Town, State	
_	4 Donation 5 Other (Sp	pecify)	FIR		T CHURCH)3- <u>1</u> 5-		MAP	PSVILLE	, VIRO	GINIA
	21. Signature of Funeral Service	Busin	'/	Ž	2. Name and Addre VILLIAM C 321 S. PH	BROWN	COMM CPHIA	UNITY BLVD,	FUNI ABE	ERAL HO RDEEN M	ME-HAR	RFORD
	23a. Part (. Errer he disease, or osh di, or heart failure. List o	complications that ca	aused the deatl					1701			Approxim Interval B	nate
	Immediate Cause (Final disease or condition	SEN									Onset an	
	resulting in death)	-	or as a conseq	,							ان پ	
	Sequentially list conditions,	b. TOXIC	EPIDER		NECROLY	315					5 D/	975
1	Cause (Disease or injury that initiated events	Due to (or as a conse	uence orja						-		
	that initiated events resulting in death) Last	c Due to (or as a conseq	sequence of):								
		d										
	IF FEMALE:											
	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Feta	Ideath 3	Ectopic pregnancy					23d. Date of delivery Month Day Year		
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□Unkno	ant at time of d wn	eath 5[Other (specify) _				Workii Day ii			
F	Part II. Other significant conditio	ns contributing to de	ath but not res	ulting in the u	inderlying cause giv	ren in Part I.		23e. Did to	bacco us	se contribute to	the cause o	of death?
								1 □ Y	es 2[]No 3□Pr	obably 4	Unknow
						24a. Was a	24b. Were au	ere autopsy findings available				
-	and the second s				autopsy performed2 1 Yes 2 X No					prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
-	25. Was case referred to medical examiner?					26. Place	of Death (C	heck only or				
	1 ☐ Yes 2 ☐ No			ER/Outpatie	IL SELDON		rsing Home	5 🗆 Resid	ence 6	Other (Spe	cify)	
	27. Manner of Death 1 Natural 5 ☐ Pending	'	of Injury h, Day Year)	28b. Time o Injury	Wo			Describe h	ow injury	occurred /		
2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street)								treet and	eet and Number or Rural Route Number			
4 ☐ Homicide determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural R City or Town, State)											10010 14	
	29a. Certifier 1 CertifyIng (Check only one) 2 Medical E	g Physiclan: To the Examiner: On the ba and mann	asis of examina	wledge, dear	th occurred at the to	me, date and opinion, deat	d place, and th occurred	due to the dat the time, d	ause(s) date and	and manner as place, and due	s stated. e to the caus	e(s)
-	29b. Signature and title of certifier	29c. License number			1 2	29d. Date signed (Month, Day, Year)						
	Komern Ras	RE	RES-000			MARCH 4, 3008						
-	30. Name and address of person v	who completed cause	e of death (Item	n 23a) (Type.					any (-(1 0)	woo 0	
6.3	JONATHAN BERGER M	n.D. 4940	EASTERL	1 Avenu		nore,	MD	21225				
	31. Date filed (Month, Day, Year)	32.	gistrar's Signa		0-10	,						
	MAR 1 1	2008	HIND I	ST A	244							
		a please with	Strate a rest	8								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 03 3. Time of Death **Physician** 1754 P M 2008 liano /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) 4c. County of Death Examiner REGIONAL Mounion If Under 1 Year | If Under 24 Ars. 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) Baltimore, MD ecurity Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 20,1959 Usual Besidence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;" or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner. 1 Yes 2 No Director Joppa 10e. Street and Number 10g. Citizen of What Country? 708 Falcone Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 W No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No à q 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) borer Jenera 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) mother 20c. Location -20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Forest Hill 4 □ Donation 5 □ Other (Specify) sport Dr., Forest Hill, MD 21050 21. Signature of Funeral Service Licensee Evans Funeral Chapel + Cremation Services - Bel Air mace or complications that da 23a. Part1. Enter the disea shock, or heart failure d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit physician s the burial Box 68760, Physician/Medical as the attending IF FEMALE: for use a If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. I 9□Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 □ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

Salisbuny Md. 21801

100 E. CARROLL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State	of Maryla			f Health and N of Death		ien e () (19. No.	8	0//89	
	Physicia	- 60	1. Decedent's Name (First Middle	, Last)					2. Date of Deat Month	h Day	Year OS	3. Time of Death 2376 M	
	/Medic Examin		4a. Facility Name (If not institution Anne Arundel M	_			4b. City, Tow	n, or Location of Death	1	4c. County		Arunde1	
	Funeral Director		5. Social Security Number 286–36–7272	6. Sex		s. last birthday) Yrs.		ear If Under 24 Hrs. ys Hours Min.	8. Date of Birth (Month, Day, April 2:	Year)	9. Birthp Coun	olace (State or Foreign htry) OH	7
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County MD Ann	e Arundel		City, Town or Lo	cation	Hanover			1	0d. Inside City Limits 1 ☐ Yes 2 📉No	
	death with the Maryland ms 23a or 28a-f show	Direct	10e. Street and Number		L		10f. Zip Co		1	0g. Citizen of V		ntry?	
		by Funeral Director	7674 Ridge Cha	12. Was De Armed I 1 TYYes If Yes, 0			Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - Americ k, White,	can Indian, etc.	
212-0030	within 72 hours after ene. then "naturel", or ite he Medical Exercitie	Completed b	3 Widowed 4 Divorced 15. Decedent (Specify only highest Elementary/Secondary (0-12)	st grade completed		16a. Dece (Give life.	dent's Usual O kind of work d DO NOT use re	ecupation one during most of wor stired)	rking	16b. Kind of Bu	siness/In		
and 21,	be filed wit tal Hygiene d other the	Be Con	17. Father's Name (First, Middle,	Last)	<u> </u>	Fa	cilitie		ne (First, Middle, i	Maiden Sumam	e)	of Defens	e
магуіа	d Men narke	၉	Harold B. Gout 19a. Informant's Name/Relations	hip (Type, Print)	/			reet and Number or Ru		, City or Town,	State, Zip		
more, r	Pages 1 and 2 st ment of Health and lant: If Item 27 is n jury or other traun	1	Mrs. Margaret . 20a. Method of Disposition 1 Burial 2 TyCremation 4 Donation 5 Other (S	3 □Removal fro	20b m State	. Place of Dispo cemetery, crea	osition (Name on matory or other	Chapel Ro	Date	20c. Location -	City or To		
Balt	permit. Departm Importar any injur		21. Signature of Funeral Service	Vanura	/no	22 2/35 7 S	2. Name and A	n Funeral	2nd Ave & Cremat:	, SW ion Ser	G1en	Burnie, M s 2106	D
	Physician		23a. Part1. Boter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that only one cause or	t caused the de n each line.	ary fa	ter the mode of	dying, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	/Medical Examiner	7.0		b	of or as a cons	ration	pnei	i morria,	reple	ted		Weeks	
50,	cate be executed oblysicien and the burial-transit	ıi Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	On o (or as a cons	equence of):	Bro	en Jon	ige .			Weeler	
. Box 68/60	ath certifications is as as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Liv	outcome of present time of present at time of	etal death 3	□Ectopic pregr				te of deliv	ery Day Year	
ds, P.O	uires that the de signed by the a d be detached		9 Unknown Part II. Other significant conditi			resulting in the u	underlying caus	e given in Part I.	23e. Did to			the cause of death?	n
I Records,		Completed							24a. Was a autop perfor	sy med?	prior to co death?	opsy findings availabl ompletion of cause of 2 No	е
n of Vital	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1	Hospital: 28a. Da	Inpatient 2 te of Injury onth, Day Year	ER/Outpatie		Other	ath (Check only of Home 5 Resid	ence 6 🗆 Oth		fy)	
Division of	ofter death efter death Director:	Certification;	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	nined 288. Pla	ace of Injury - A ilding, etc. (Sp	at home, farm, si ecify)			28f. Location (S City or Tow		per or Rur	ral Route Number,	
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifyi	Examiner: On the	the best of my basis of exam anner stated.	knowledge, dea nination and/or in	nvestigation, in	he time, date and plac my opinion, death occ	urred at the time, o	date and place,	and due	to the cause(s)	
)	To t To t	Σ	29b. Signature and title of certific	l)	Fle	wt4 m	0	D 2143	88 9	29d. Date signe Mesco	ho	5,2008	
	13		30. Name and address of person MICHAEL 1. L. 31. Date filed (Month, Day, Year	aleNTA	ause of death (W Y Resistrar's Si		WSEHT	SHWAY A	NNAPOLI	s MAI	1401		
100	Sta Regist				No.	K	hails)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM/20 per INF. C877 3/21/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 Steven Douglas Garland March 7:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1108 Armistead Street Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□F 219-70-6960 49 Director Aug. 26, 1958 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Armistead Street 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Marland State Highway College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. the Administration Engineer 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last is 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be Ronald E. Garland Mary Jean Tate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kimberly G. Garland/Wife 1108 Armistead Street Glen Burnie, MD 21061 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 203 Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2008 Glen Haven Mem. Park Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation MCs/357 Serivices 1 2nd Avenue SW Glen Burnie, MD 21061 anun 23a. Part1. Enter the disease, or complication shock, or hear failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence off requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. physician the burial Physician/Medical as IF FEMALE: ase a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only of 21X10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural
2 Accident 5 Pending Injury n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu 1 Yes 2 No death. investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye

10

State Registrar 30. Name and address of person who

Year

31. Date filed (Month, Day,

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

(0

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

DOCTOR

Harbor Auspited 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bashir

29c. License number

Res ool

29d. Date signed (Month, Day, Year)

March 6,2008

3001 South Hunover street, Baltimore, Maryland 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March Henry Griebel 7008 Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner dale Franklin If Under 24 Hrs If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 1X1 M 2 □ F Yrs Director 217-30-3202 73 7,1934 Maryland Aug. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No notifled Directo 28a-f Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö must be or Items 23a 21222 United States 1717 Melbourne Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status injury or other traumatic event, the Medical Examiner Black, White, etc. Armed Folces: 1 Description | 10 Per | 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: à 3 Widowed 4 Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Steel Industry 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 2 Evelyn Gibbons Philip Frederick Griebel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan L. Griebel (Wife) 1717 Melbourne Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tx Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 3/10/2008 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 19C Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy 2 Fetal death for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) P.O. the detached 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by law requires 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 No Division or Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ŽN No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 DOA After this 27. Manner of Death To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year, Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

ORIGINAL

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Sta	Maryland er verb	d / Depa	artment of F 7,03/121/0	lealth and I Sabb n	Mental Hy	giene Reg. No. 2 ()	n a	07793
PI	hysici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
- set	/Medic	al	Florence Paul Griffit 4a. Facility Name (If not institution, give street and nun			4b. City. Town, o	r Location of Death	Februa	ry 22 2	2008	3:00p M
)	xamin	er	13755 Barberry Way	,,,,,,		Sykesvi	11e			vard	
	neral ector			7. Age (<i>In yrs. I</i> 88	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	9. Birthpla Count	
D D	in Super		Usual Residence of Decedent		, Town or Lo	l		April 6	1919	146	MD
Maryla	ied at	tor	MD 10b. County Howard		esvil]					10	od. Inside City Limits 1 ∐Yes 2 (☑) No
ith the	e notif	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
eath w	must b	Funeral	13755 Barberry Way 11. Marital Status 12. Was Dece	dent Ever in U.	S. 13	21784	lispanic Origin? (S	necify Yes or No	USA 14. Bace	e - America	n Indian.
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	nen z.r.is maned over then liatural , or rems zoa or zoar sirow other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ☐ Y	rces? 2 X No e		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Blac	k, White, e	tc.
15-0	dical	leted	15. Decedent's Education (Specify only highest grade completed)	7	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/Ind	ustry
21215-0036 d within 72 hours afi gjene.	the Mc	Completed	Elementary/Secondary (0-12) College (1	-4or 5+)		il sales	´		retail	sales	3
Maryland 2 INaryland 2 Id 2 should be filed v Ith and Mental Hygie	tic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Paul A. Paul				18. Mother's Nan Blanche	, ,	Maiden Surnam	ne)	
Magary Age	er trauma		19a. Informant's Name/Relationship (Type. Print) Debra Finkelsen (daughte	r)		ng Address <i>(Street</i> Barberry					Code)
Baltimore, bermit. Pages 1 ar Department of Hea	ury or oth		20a. Method of Disposition 1 ☐ Buria! 2 【** Cremation 3 ☐ Removal from 5 ☐ Other (Specify)	Ctoto Co	emetery, cre Count	osition (Name of matory or other place y Cremat:	ion 2-25		20c. Location - Sykesvi1	le, M	ID .
Baltimo	any Inj once.		21. Signature of Funeral Service Licensee Page August Lerbaen	オ		2. Name and Addre					Chapel
Physi			23a. Part1. Enter the disease, or complications that contains the cont		- 1	ter the mode of dyir	ng, such es cardiad	or respiratory a	rrest,	1.0	Approximate Interval Between Onset and Death UFFLS
/Med Exam				or as a consequ	_						<u> </u>
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequ	ence of):						
58760, ficate be executed physician and	the burial-transit			or as a consequ	ience of):						
687 rtificate	as the	Medical	d								
the death certify the attending	stached for use as	Physician/Me	in the next 12 months?	come pf pregna irth 2 □ Fetal ant at time of de own	death 3[Ectopic pregnancy Other (specify)	/		23d. Dat Mo	e of deliver	y Day Year
- L	should be deta	þ	Part II. Other significant conditions contributing to de	ath but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did t	,		e cause of death?
I KECOTOS, The law requires to the has been signer		Completed						24a. Was autop perfo	rmed2/	Were autoporior to corr death?	osy findings available apletion of cause of
Or VITal Physician: T	rector, page 2	Be	25. Was case referred to medical examiner? Hospital:			Louis		th (Check only o			
F y sir	9 0	n: To	27. Manner of Death 28a. Date of	of Injury	28b. Time o	nt 3 DOA Oth f 28c. Injui Wor	4 □ Nursing H		dence 6 Oth)
SION ending eath.	the fun	atio	2 Accident investigation	h, Day Year)	Injury		K? Yes 2 □ No				
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DIVISION O To the Hospital or Attending Pi within 24 hours after death.	pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and mann	asis of examinat	wledge, deat ion and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
ToT	100	Σ	29b. Signature and title of certifier	m.		29c. Licens			29d. Date signed		
113	5)	-	30. Name and address of person who completed cause 5		23a) (Type,	Print) Si Plumo	acilan M	Silved	Shine	MA	<u> </u>
R	Sta egistr	_		egistrar's Signat	ture	K)	-chanti IX	SHYEK	Srivij	עוויי	

DHMH 17 Rev 1/2001

		,	For State Registrar	State of N	Marylan	•	artment of rtificate o			ental Hyg	iene :g. No. 200	8 07794
	Physici /Medic		DEBORAH	F			GRIES			2. Date of Deat	5 ^{Pay} 2008	3. Time of Death 9:40P M
	Examir	ner	4a. Facility Name (If not institution, give STELLA MARIS HOS	SPICE	er)		4b. City, Town	JM			4c. County of I	
	Funeral Director		3/0-00-/300	9x □M 2D X F	Age (In yrs. 48	last birthday) Yrs.	If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Birth (Month, Day, 04/18)	/1959	Birthplace (State or Foreign Country) MD
	ne Maryland 8a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County MD HARFORI)		y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 502 SPRING GUII	DE COURT			10f. Zip Code	21015	i	10	0g. Citizen of Wha	usA
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2[If Yes, Give Year or Date:	s? X No		Was Decedent o If Yes, specify C 1 ☐ Yes 2 🔏 N			ecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur event, the Medical i	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-40 4	or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti ARA-EDU	e during mo red)	ost of worki	ng	16b. Kind of Busin	ess/Industry
land 2		To Be C	17. Father's Name (First, Middle, Last) PAUL	<u> </u>			FORD	18. Moth	her's Name		Maiden Surname)	LIPMAN
Maryland	and s m	-	19a. Informant's Name/Relationship (ERIC GRIESINGER		ND	19b. Mailir		et and Num	ber or Rura	al Route Number	City or Town, Sta	
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 3 □ 1 Cremation 3 □ 20a. Method of Disposition 3 □ 4 □ Donation 5 □ Other (Specification 3 □ 20a. Method of Disposition 3 □ 20a. Method of Dispos		20b. P	Place of Disponentery, crea	sition (Name of matory or other p AL GARDI	lace))/2008	BEL AIR	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer			22	2. Name and Add	ress of Faci	ility SC	L LEVIN	SON & BR	OS., INC. LE, MD 21208
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that causone cause on each	n line.		er the mode of o	ying, such a	as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a.	as a consequ							
8760,	ficate be executed physician and street transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last	c	as a consequas a consequ		· · · · · · · · · · · · · · · · · · ·					
.O. Box 687	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	n 2 □ Feta t at time of d	Ideath 3	⊒Ectopic pregna ☑ Other (specify)	ncy			23d. Date of Month	
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or Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatier	nt 3 DOA			n <i>(Check only on</i> me 5□ Beside		(Specify) HOSPICE
Division or	ding J. After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of I (Month, I	njury Day Year) injury - At ho	28b. Time o Injury	f 28c. Ir	jury at ork? □ Yes 2 [□No	28d. Describe ho	w injury occurred	or Rural Route Number,
Ο̈́	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide determined 29a. Certifier 1 ★ Certifying Ph		etc. (Specif		h occurred at the	time date	and place	City or Town		er as stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examone)		s of examina		vestigation, in m	y opinion, d	eath occurr	red at the time, d	ate and place, and	d due to the cause(s)
	vitl Cor	_	29b. Signature and title of certifier				D(nse number	25	2	3/6/6	Month, Day, Year)
7	12		30. Name and address of person who				,	10/	- 0			
	Sta Registr		DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year) MAR 1 1 20		DULANE strar's Signa		EY RD.	TIMO	NIUM,	MD 2109	13	

DHMH 17 Rev 1/2001

MARCH 5, 2008 9:40 p.m.

DEBORAH GRIESINGER

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*	79-14		Registrar 1. Decedent's Name (First, Middle, Last)		Cei	Tillicate of	Dealli	2. Date of De	Reg. No.	3. Time of Death
ı	Physici /Media		CHARLES G	UTIN				Month 03	6th 2	Year 6.23 PM
	Examir		4a. Facility Name (If not institution, give street an	d number)			r Location of Death		4c. County	
	- Famour		STELLA MARIS HOSPICE 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	TIMONIUM If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	BALTIN	
ij.	Funeral Director		216-48-0841 1X M 2			Months Days	Hours Min.	03/16	71947	9. Birthplace (State or Foreign Country) MD
	land bw it		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	MD BALTIMORE	BAL	LTIMOR	lΕ				1 □Yes 2 No
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code	1015		10g. Citizen of V	Ť
	eath v	eral	6906 BLANCHE ROAD 11. Marital Status 12. Was	Decedent Ever in U.S	S. 13.		1215 Hispanic Origin? (Spe	cifv Yes or No	- 14. Rac	USA ee - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 M Never Married 2 Married 1 If Ye	ed Forces? Yes 2 ☐ No s, Give or Dates:		If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rićan, etc.)	Specify	ck, White, etc. y: WHITE
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212	d withi giene. er than the M	omo;	Elementary/Secondary (0-12) Colle	ge (1-4or 5+) 4		VENUE EX			STATE (OF MARYLAND
	be file tal Hy d othe event,	a	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle	, Maiden Surnan	•
Maryland	hould d Mer marke	2	MILTON 19a. Informant's Name/Relationship (Type. Print)	GUT I		REVA and Number or Rura	l Route Numb	ner City or Town	ABRAMS State Zin Code)
	und 2 s alth an 27 Is i		LAWRENCE I. GUTIN /				IELD LANE,			
Baltimore,	Pages 1 and the subsection of		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal	from State C6	emetery, cre	osition (Name of matory or other pla	ce)	ate		City or Town, State
Him	it. Pag rtment rtant: njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ✓	HE		YOUNG MEI 2. Name and Addre				MORE, MD
Ba	perm Depa Impo any i		Anth M. W.	ttle						ROS., INC. LLE, MD 21208
Sport	Physician		23a. Part1. Enter the disease, or complications is shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	19. 6. 1		ter the mode of dyli				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequ						
	nsit 74 të	Examiner	cause. Enter Underlying Cause (Disease or injury	e to (or as a consequ	ence of):					
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6876	cate be physici the bu	dical	d							
.O. Box	The law requires that the death certificate be the has been signed by the attending physicia agge 2 should be detached for use as the bur	Physician/Medica	in the past 12 months?	s, outcome pf pregnar Live birth 2□ Fetal Pregnant at time of de Unknown	death 3[□Ectopic pregnanc □ Other <i>(specify)</i> _	у			ate of delivery onth Day Year
<u>α</u>	luires that signed b	þ	Part II. Other significant conditions contributing	to death but not resul	Iting in the u	nderlying cause giv	ven in Part I.			tribute to the cause of death? 3 Probably 4 Unknown
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10 L	ding Physician:). After this certific funeral director,	n: To	27. Manner of Death 28a.	· · · · · · · · · · · · · · · · · · ·	28b. Time o				how injury occur	red (Specify) HUSDICC
Division	Attending r death. ector: After by the fune	catio	2 Accident investigation			M 1 🗆	Yes 2□No	Of Leastien	(Street and Number	how or Burni Bouto Number
Divi	after of Direct of in by	Certification:	determined 200.	Place of injury - At hor building, etc. (Specify)	nie, iami, sii	reet, factory, office			wn, State)	ber or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On and							
	To t. To t.	X	29b. Signature and title of certifier				3725		3/6/	
	8			000 10	23a) (Type,	dye E	load V	Vestr	nin iste	er MD 21157
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 2008	SZ Negistrar's Signat	1 19	1048				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrat Certificate of Death Decedent's Name (First, Middle, Last)
 Anthony Tyrone 2. Date of Death 3. Time of Death - ^{Day} 2008 Month Hines **Physician** 3:26 a^M March 5, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's County Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 242-84-9875 54 117 M 2 □ F 01/08/1954 Director NC Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State I7 is marked other then "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD Prince George's Laure1 1XYes 2□No Director 10e. Street and Num 10g. Citizen of What Country? Harvest Bend Lane Apartment 20707 with USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Item eny injury or other traumatic event, the Mudical Experimenone. Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hines Edward Ella Morris Jones Lemue 1 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8204 Harvest Bend Lane Apartment 33, Laurel Date Date 20c. Location - City or Town, State 2077 В. Hines / Wife Debra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gardens Of Gethsemane 3/15/2008 Rocky Mount, NC 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. Mous Shar 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Bilateral Cerebral Infarction /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and death certificate be execu Due to (or as a consequence of) atending physicien for use as the hirrar Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown The law requires that the 9 🗌 Unknown ns certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 XNo 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending death. 1 Yes 2 No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ophnell Cumberbatch M.D. 3001 Hospital Drive, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 🕏 Registrar's Signature. State MAR 1 1 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** ROLAND HANDY 4:20 A M MARCH 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE MANOR CARE TOWSON RUKTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 27, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2□ F 91 Yrs. 214-12-8543 Director Marvland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3304 Tanev Road 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: Black <u>Ş</u> 3 Widowed 4 ☐ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter J. Handy Rosina Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolanda V. Rawlings, Daughter 3304 Taney Road Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/08/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ROS TATE 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1∐ Yes 2 🗆 No 2 10 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after To the Funeral Dir

State Registrar

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29b. Signature and title descrifie

31. Date filed (Monty Aan Year) 1

LEONARD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RYAr)1 2008 32. Tegistrar's Signature

M-P.

29c. License number

D57722

1838 GREENE TREE ROAP \$300 PIKESVILLE MP 21208

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month Physician 2002 Gloria Heady /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN AMNE AGUNDEL HOUZNIE TAKING RELOAPHINGTON METOCAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔽 F 55 MAR 6, 213-62-9028 Virginia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: Unity or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director MDBaltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2721 Yarnall Road 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 Married Marylard 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Toll Collector 12 State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warr<u>en</u> ပ Joyce <u>Annie</u> <u>Edwards</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Warren Heady, son 2721 Yarnall Road 21227 Halethorpe, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc.: 03/07/08 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD My 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LUNG CANCE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed L pue Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 yes 2 No
9 Unknown Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1
☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Tyes 2₩ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2008 7 Name and address of person who completed cause of death (Item 23a) (Type, Print) Gien Burne MD 20161 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

MAR 11

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HUNGER Year Physician MATIL DA 200 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 408 Kentucky Pasadena
If Under 1 Year | If Under 24 Hrs. Anne Arundel Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M Yrs Director 11-17-1921 Maryland 220-07-440] Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f show I Examiner must be notified at 1 Yes 2 No Director MD Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2]]22 U.S.A. 408 Kentucky Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 → Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Joseph Oswinkle Barbara Horst ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Kentucky Avenue Pasadena MD 2]]22 item 27 i Daughter Connie Kane 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot Oak Lawn Cemetery 03-]]-2008 Dundalk Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Dundalk Inc Duda-Ruck F Aven<u>u</u>e Dundalk Wise 7922 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** w disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner len scuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed MEN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

To the within the property of
State Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

MAR

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** par bara arch Shoson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** roll If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs last birthday) 1960 Have de Grace, MD **Funeral** Sex 1 □ M 2 F Months Days Hours Min. Director 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 No **Funeral Director** Tantoic 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2116 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No 1 Yes Specify: Specify: Completed by nite 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Frint) timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Borial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 22. Name and Address of Facilit BNLW 21. Signature of Funeral Service Licenses FOREST Evans Funera O Chapel-Cremation Services 23a. Part1. Enter the dise se shock, or heart failur. e, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEATTIS YEMR 5 Circhosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No funerall director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsv performed? res 2 240 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2 00056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pper Chisapeake 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-01908 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carroll Pearce Jipson State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Death Month Day March 7, 2008 Medical Examiner 1041 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours oreign Director Country) 1 M 2 F aine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No notified at once hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Was Decedent Ever in U.S. Armed Fore If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married Yes 2 If Yes, Give Year Examiner 4 Divorced Yes 2 No specify: Specify: "natural" \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. If item 27 is marked other than her traumatic event, the Medical 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Itimore, or other Burial 2 K Cremation 3 Removal from State ment (Donation 5 Other Specify: 21. Sonature of Funeral Ser ice Licensee 22. Name and Add ass of Facility Baltimore, MD napelat remotions Part I. Enter the disease, or pomplications that glused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List nly q Between Onset and /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit executed Physician/Medical X UNPENDED AMENDED23a, 27 per ME g879 5/2/08 amh signed by the attending physician be detached for use as the burial -To the Inospiral or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural Director: 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

X

State Registrar

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Margarita Korell MD.

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30. Name and address of person who completed cause of death (Item 23a)

hel

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 **Physician** Jaso /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner aldwir Lane 8. Date of Birth (Month, Day, Year) April 11,1920 9. Birthpiace (State of Fig. 2) Baltimore, MD. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 F 87 Days 213-14-4990 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford County Baldwin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3108 Brandon Hunt Lane 21013 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than aumatic event, the Mr Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Miller, M.D. Emma Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important; if item 27 Is any Injury or other trau Mr.Daniel F. Kardash 3108 Brandon Hunt Lane (Son) Baldwin, Maryland 21013 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel March 08, 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Péaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium,Maryland 21093 21. Signature of Funeral Service Licens se, or complication that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one all se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE WEEKS /Medical Due to (or as a consequence of) Examiner OCHEDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has b irector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending 24 hours after death. completely within 2.

Registrar

29b. Signature and title of certifier

BELING

(Check only one)

JAMES

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7401 OSCER DRIVE SUITE 101 TOWSON

31. Date filed (Month, Day, Year) 2008

32. Poistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 2008ar Minna Clara Knighton 1:30 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Upper Chesapeake Medical Center Harford County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | (Months | Pay 1 9 | 1902) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 212-74-8913 1 □ M 2 🕅 F 105 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Baltimore County Baldwin Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5001 Carroll Manor Road 21013 United States **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ZHNo Specify: Be Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Kopp Clara Kram ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Davey (nephew) 1737 Amuskai Road Parkville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 09 MARCH of Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Peacerul Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Panta. Effer the distate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, of hair fail. a. List only one rause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Day Year 5 ☐ Other (specify) 2 🗹 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/outpatient 3 □ DOA 1 ☐ Inpatient Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical

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neral Director: After this y filled in by the funeral di

Funeral

Director

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Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiend Important: If Item 27 is marked other ths and injury or other traumatic event, the once.

Physician /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after

21215-0036

Maryland

Baltimore,

800 488 084

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n Jahron

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

2005

pper chegupate Dr. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

State Registrar

within 24 hours a

To the Funeral I To the Hospital

Physician

/Medical

Examiner

Funeral

Director

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Or				Cremation 3 □	Removal from State	ce	metery, crem	ition (Name of atory or other pla	· i	Date		Location - City or	
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or Vii	Physicia r this certi ral directo	Ω	examiner?		Hospital: Inpatier	nt 2 🗆 E	R/Outpatient	3□ DOA Oth		ce of Death <i>(Check only</i> Nursing Home 5 Res		Δ []OH - /O-	76.3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9 05 03 07 Clara Kochanski 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimare If Under 1 Year Johns Hopkins Bayview Medical 5. Social Security Number J 6. Sex Center If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2€XF 218-07-1211 86 Director Mar13,1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Experiments 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Md. 1 ☐ Yes 2 ☐ No Baltimore City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 Imla Street 21224 U.S.A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: þ White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Fisher Rose Pawlak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kochanski (son) 3521 McShane Way Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Stanislaus Cem 3-12-2008Baltimore, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facilitaczorowski Funeral Home. PA Foliat 1201 Dundalk Ave. Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Severe mitral stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of). attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division or Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

RES-000

29d. Date signed (Month, Day, Year) 03, 07, 2008

4940 Eastern Avenue Baltomare, MD 21224

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda Chu, M.D. Johns Hopkins Bayring Medical 31. Date filed (Month, Day, Year) 32 Registrar's Signature

MAR 1 1 2008

		1 _ State	Maryland / Depa	artment of H <i>rtificate of I</i>				8 07806
5		Registrar 1. Decedent's Name (First, Middle, Last)				. Date of Deat	h	3. Time of Death
Physic /Med		Helen Leona Kahl	er			Month 03	06 2008	0243 A M
Exami		4a. Facility Name (If not institution, give street and num	Α 1		Location of Death		4c. County of De	
	2.36	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	RoseO	If Under 24 Hrs. 8	. Date of Birth	9. 8	MOT Sirthplace (State or Foreign
Funeral Director	T T	213-34-1778 ^{1□M 2} √2F	70 Yrs.	Months Days	Hours Min.	(Month, Day, uqust	^{Year)} 28, 1937	Country) MD
pu ,	1	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ncation				10d. Inside City Limits
Aaryla f shov ed at	٥							1 □Yes 2 No
the N 28a-i notiff	Director	Md Baltimore 10e. Street and Number	Dundal	10f. Zip Code		10	0g. Citizen of What	Country?
th with	a D	220 Robwood Rd.		2]222			USA	
r deal	Funeral	11. Marital Status 12. Was Dece Armed For		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.
15, INIAL YIALIO 2 12.12.10000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. thealth and Mental Hygiene. them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☒ Divorced Year or Da	е	1 ☐ Yes 2 🔀 No	Specify:		Specify:	hite
2 hou		15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	
thin 7 le. lan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	-4or 5+)		during most of working i)			
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d be fi	Be C		• • •					
c, Intal ylation 2.12. 1 and 2 should be filed within Health and Mental Hyglene. em 27 is marked other than wither traumatic event, the Me	2	Patrick Francis O'No 19a. Informant's Name/Relationship (Type. Print)		ng Address (Street	Leona I and Number or Rural I			e, Zip Code)
and 2 salth a salth a 127 is		Patricia L. Murphy	732]				e,MD. 21	
Pages 1: nent of He int; If iten	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 5	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce) Dat	te	20c. Location - City	or Town, State
t. Pag rtmen rtant;		□ Donation 5 □ Other (Specify)		Servic	e Corp 3	/7/200	08 Tow	son,MD 1 Home of 2 Dundalk
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	4	21. Signal re of Funeral Service Licensee	00 5	7922 Wis	e Ave. Di	a-Rucs undalk	MD 212	Dundalk 22 Inc.
b.		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	2D5iS					Onset and Death
/Medical Examiner		resulting in death)	or as a consequence of):					
(20)		Sequentially list conditions, if any, leading to immediate b.	or as a consequence of):					
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icate be executed physician and the burial-transit	dical	d						
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he law has l ge 2 s	du					autops perfor	sy prior ned? deat	to completion of cause of
an: T an: T tifficate tor, pa	Be Co	25. Was case referred to medical			26. Place of Death (2 No 1 1 1	res 2□No
hysici nis cer	To B	examiner? 1 Yes No Hospital:	npatient 2 ☐ ER/Outpatie		4 □ Nursing Hom	e 5 🗆 Resid	ence 6 Other (S	Specify)
ing Phr After thi		Tatalal Oli Chaing	of Injury 28b. Time of h, Day Year) Injury	Wor	ry at 28 rk? Yes 2 □ No	d. Describe h	ow injury occurred	
Vittend death ctor: ,	licati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of injury - At home, farm, st					r Rural Route Number,
affer affer d in b	Certification:	4 ☐ Homicide determined buildi	ng, etc. (Specify)			City or Tow	n, State)	
To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only 2 ☐ Medical Examiner: On the bar	best of my knowledge, dea	th occurred at the ti	me, date and place, ar	nd due to the o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
the Phin 24 the F	Medical	one) and many 29b. Signature apertitle of centifier	ner stated.	29c. Licens			29d. Date signed (M	
Mit Vit	-	Birds 1791 11	1. 1 NOUYE	/ -	06509	11	3/061	08
10		30. Name and address of person who confleted says	e of death (Item 23a) (Type.	Print)		7	/ /	
1	1	Dr. Binh Nauxenrate	100 Franklin	Square	Drive, Bo	altim	ore, mi	21237
S Regis	tate	31. Date filed (Month Day, Yar) 2008	egistrar's Signature	and the same			,	
negis	trui							

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and I Certificate of Death		giene 008	07807
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Henry Lee Kellum	2. Date of Dea Month	Day Year	3. Time of Death 6 1, 2574 M
	Examir		4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Location of Death	7-1	4c. County of Death Pnnも	Brudel
	Funeral Director		5. Social Security Number 223-28-9622 6. Sex 1 X M 2 F 83 Yrs. 81 Worth Page 14 Hrs. 15 Months 15 Months 16 Months 17 Months 18 Months 1	8. Date of Birth (Month, Day Aug . 1	9. Birth 6 1924	pplace (State or Foreign untry) VA
	Maryland -f ehow	lor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Glen Burni	e		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a-	Funeral Director	10e. Street and Number 313 Hospital Drive 10f. Zip Code 21061		10g. Citizen ol What Co	
900	portiliories, Intelligible 2 12.13.0030 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event. The Maulical Examinal must be notified at once.	5	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puert If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert If Yes, Give Year or Dates:	pecify Yes or No- o Rican, etc.)		ican Indian, , etc. Nite
Monday of the Const	d within 72 hogiene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Maintenance	king	Anne Aru Public	ndel Co.
2	Mal y Idlio Z IZ I	To Be			<i>Maiden Sum</i> ame)	
	NG 2 Shoulth and No. 27 is man	_	19a. Informant's Name/Relationship (Type, Print) Bernice Adams (sister) 19b. Mailing Address (Street and Number or Ru 615 B Street, Pasader	ıral Route Numbe	r, City or Town, State, 2	ip Code)
	Pages 1 er		20a. Method of Disposition 1 \Rightarrow Burial 2 \Boxed Cremation 3 \Boxed Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) March	Date 10	20c. Location - City or Crownsvile,	
	permit. Departmine importa		21. Signature of Funeral Service Libensys 22. Name and Address of Facility 3111 Mountain Roa	Stalli	ngs Funeral	Home, P.A.
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	dis	in se	
2	ificate be executed g physicien and as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
2		edlcal	d			
16	E 2	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)		23d. Date of deli Month	very Day Year
X System	quires that the signed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	the cause of death?
7 0	vician: The law recentificate has bee	Completed		24a. Was autop	sy prior to death?	topsy lindings available ompletion of cause of
3	ician: certific ector,	Be	examiner?	ath (Check only o	ne)	
7 7	fing Phys	ıtlon: To	1 Yes 2 No Hospital: npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing H 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No		lence 6 Other (Spec	ify)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	28I. Location (S City or Tow	Street and Number or Ru In, State)	ral Route Number,
	Hospital 24 hours a Funeral etely filled	Medical C	29a. Certifier (Check only one) Check only one)	, and due to the d pred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier 29c. License number D4 8006	(29d. Date signed (Mont)	Day, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dr.	5 lan Br	and hun
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 2008 33 Figistrar's Signature	,		•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death **Physician** 4:17 PM Marion Harch 7,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🙀 F 099-24-8274 Director 91 Aug. 10, 1916 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r 28a-f show notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be r 5721 Grosvenor Lane 20814 United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Curth Clara Supper 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Francis R. Kesterman/Son 4 Winterberry Court, Bethesda, Maryland 20817 20b. Place of Disposition (Name of The Evergreens 20a. Method of Disposition 20c. Location - City or Town, State Pages March 12, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brooklyn, New York Cemeterÿ 2008 21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility
Robert A. Pumphrey
Robert A. Pumphrey
Funeral Home/
Chase, Inc.

Bethesda, MD 20814-3501

Approximate
Internet failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off Physician/Medical Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Jonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 1 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2[] No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation To the Hospital or Attenums within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide i 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

DHMH 17 Rev 1/2001

SIERMAN, MARION

State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend 16a Certificate of Death perFH. C877 3/11/08 TT 2. Date of Death Physician Den19 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death Ba Tum **Examiner** Baltomore 2 CANDLEMAKER COURT, APT. 101 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Months Hours 01/08/1918 092-09-9134 90 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ò must be 2 CANDLEMAKER COURT, APT. 101 21208 USA r than "natural", or Items 23a the Medical Examiner must b filed within 72 hours after death Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11 Marital Status Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: HITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
PRESTA DENT use retired)

- Maxedosedical pa 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) MONMOUTH ADVERTISING 12 MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I DAVID KOENIG EVA COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEARL KOENIG / WIFE CANDLEMAKER COURT, APT. 101, BALTIMORE, MD 21208 Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State FREEHOLD HEBREW Place) BENEFIT SOCIETY 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 03/09/2008 FREEHOLD TOWNSHIP, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ig physician and as the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. if yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Vear 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 No 1□ Yes 2DNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**1**] No ပ 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. Phy siclar

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State Registrar CRUSSRAADJAR ONINGSMILLS MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 44 AM WILSON JOHN LAMO. 2008 MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1XM 2□F 579-30-1362 80 June 10, 1927 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 X No Maryland Baltimore Baldwin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13826 Manor Glen Road 21013 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2□No 1944 If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1∐Yes 2ŽŽNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isabelle V. Watson Herbert C. Lamp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Lamp (Wife) 13826 Manor Glen Rd., Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hebron Cemetery 3/15/08 Winchester, VA 22 Name and Address of Facility
Michael R. Phelps & Associates
5095 Main St., Stephens City, VA 22655 21. Signature of Furieral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NTRACRANIAL 2 HOURS HEMORRHAGE Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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Funeral

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show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

death with the Maryland

burial-transit funeral

law requires that the death certificate be executed physician the Hospital or Attending hin 24 hours after death. the Funeral Director: After

Division or Vital Records, P.O. Box 68760,

within 2

dical E		■d	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Completed			24a. Was an autopsy findings availat prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
a	25. Was case referred to medical	26. Place of Death (0	Check only one)
To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? I ☐ Yes 2 ☐ No	d. Describe how injury occurred
Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	i. Location (Street and Number or Rural Route Number, City or Town, State)
cal (ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred	

29c. License number

EASTERN

ORIGINAL

RES-000

29d. Date signed (Month, Day, Year)

AVENUE BALTIMONE, MD 21224

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32. Registrar's Signature

TIFFANY, M.D.

MAR 1 1 2008

		For State Registrar		State of Ma	aryland		rtment of <i>tificate of</i>			/lental H	ygiene Reg. No	-24111	8 07811
Physicia	n		ne (First, Middle, Las	. /						2. Date of D	Death	ıv — Year	3. Time of Death
/Medica	al -	4a. Facility Name	(If not institution, give	e street and number)			4b. City, Town,	or Locati	ion of Death		3	. County of Dea	18 155 AM
Examine	1	Morni	igside Ho	use-Saty		.11	Park	Wil	11e			Balto	noke
Funeral Director		5. Social Security I 293-07. Usual Residence of	-7505 1	ex 7. Ag	8 9 g	ast birthday) Yrs.	If Under 1 Year Months Days		nder 24 Hrs. Irs Min.	8. Date of E (Month, E		8 P. Bi	rthplace (State or Foreign Country) ARY ANG
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with the Maryland a or 28a-f show be notified at	Director	MD.	Baltimo	ore	Pā	arkvi					1.40= 0:	Aires of lathest C	1 ☐ Yes 2 X No
h with t		10e. Street and Nu 9241 H		Jiew Driv	re		10f. Zip Code 21234	l			10g. Ci	tizen of What C	ountry?
ours after death w ral", or items 23a Examiner must b	by Funeral		rried 2 Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu ☐ Yes 2X No			pecify Yes or No Rican, etc.)	10-	14. Race - Am Black, Wh Specify: W	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed	(Spe	15. Decedent's Eccify only highest gra	lucation de completed) College (1-4or 5	i+)		ent's Usual Occu kind of work done OO NOT use retire		most of worl	king	ï	Kind of Busines	•
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Pages 1 and of Heamint: If item			•	Removal from State		ace of Dispos emetery, cren	sition (Name of natory or other pl d Cemet	ace)	02/1	Date 10/08	20c. L	ocation - City o	or Town, State
permit. Departr Importa any inji		21. Signature of F	funeral Service Licer	See EVU	12	£₹ 88	Name and Add Vans Fu 300 Har	ress of F iner for	al Ch d Rd.	napel . Park	& Ci	remati le, MD	on Services 21234
				plications that caused one cause on each lin		. Do not ente	er the mode of dy	ing, suc	h as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause disease or conditi resulting in death)	on	a. Due to (or as		ence of):	-						Years
Examiner	_	Sequentially list c	onditions,	b. Due to (or as	a consegu	ence of).							
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icate be executed physician and the burial-transit	edical Ex	resulting in death)	Last	Due to (or as	a consequ	ence of):							
= 5 %	Physician/Med	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months? □ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan	су				23d. Date of d Month	elivery Day Year
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ysiciar s certif director	To Be	25. Was case reference examiner? 1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatien	t 3□ DOA O	Ale e u		th <i>(Check onl)</i> ome 5 □ Re		6 ₽Other (St	necify) Psy, Hel Living
g P		27. Manner of Dea 1 ☐ Natural 2 ☐ Accident	ath 5 □ Pending investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Inj W			28d. Describ			<u>, </u>
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injuding, et			eet, factory, office	9			(Street a own, Stai		Rural Route Number,
e Hospi 24 hour e Funer	Medical	29a. Certifier (Check only one)		ysician: To the best niner: On the basis o and manner sta	f examinat								
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10			nth, Day, Year)	32. gistr	e che.	الم المراب الم	Suite	420	70	~ 2 W	nd	2/20	4
Stat Registra		31. Date filed (Mo	nth, Day, Year)	200 32. Sgistr	ar's Signat	ure	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland				lental Hy	giene	2000	07010
			1 - State Registrar		Cer	tificate of	Death	2. Date of De	Reg. No.	2000	3, Time of Death
	Physici		1. Decedent's Name (First, Middle, Last)	- Charles	lic	nonfel	der	Month	Day	2008	J. JO A. M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	ir (car Cr)	4c. 0	County of Deat	11 1011
	··· `her	3-	5. Social Security Number 6. Sex	oint Road	at hirthday)	If Under 1 Year	dalk If Under 24 Hrs.	8. Date of Birt		altim	ore Co.
	Funeral Director			(M 2□F 58	Yrs.	Months Days	Hours Min.	(Month, Da	y, <i>Year)</i> • 1949	Balt	nplace (State or Foreign untry) Linore, MD.
P	alpan no right — alph		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loc	nation					10d. Inside City Limits
Maryla	f shovied at	ō	Maryland Baltimore		ndalk	Squoii					1 ☐ Yes 2 No
h the l	or 28a- e notif	irect	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
riarylario z 1 z 1 3-0030 2 should be filed within 72 hours after death with the Maryland	s 23a c nust be	Funeral Director	4047 North Point R				21222			ited St	
fter de	r items iner n	Fune	11. Marital Status 1 ☐ Never Married 2 ② Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No			lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No Rican, etc.)	. 1	 Race - Ame Black, White 	
UUSO hours at	ral", o Exam	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specify:			Specify: Wi	nite
72 h	"natu edical	letec	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give	ent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kin	d of Business/	ndustry
Z within	giene. r than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Computer				Comput	ers
be filed	tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			•	
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ore, jes † a	Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Pla	ce of Dispon	sition (Name of natory or other place	e) March	Date 1 10,		cation - City or	
rmit. Pages	rtment rtant: Jury o		4 ☐ Donation 5 ☐ Other (Specify)	Oak	LciWII	Cémetery	20.				Maryland
Permit.	Depar Impor any in	0.0	21. Signature of Funeral Service License	- gair, h	Pe	eaceful"/ 2325 York	Niterhativ Road '	ves Fune Timonium	eral& n,Mar	Cremat: yland	ion Ctr.,P.A 21093
			23a. ParM. Enter the disease, or complishock, or heart failure. List only of	ications that caused the death. ne cause on each line.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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The law requires that the death certific	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)	/		2	3d. Date of del Month	ivery Day Year
t the d	by the ached	hysi	1 Yes 2 No 9 Unknown	9☐ Unknown							
الم res tha	igned be det	by P	Part II. Other significant conditions con	ntributing to death but not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did t	,		the cause of death?
cords, w requires t	been s	eted	· · · · · · · · · · · · · · · · · · ·					-			obably 4 ☐Unknown
he lay	e has	Completed							psy prmed?/	prior to death?	topsy findings available completion of cause of
Ital	rtificat ctor, pa	0	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes h (Check only o	2 No ne)	1 LJ Yes	2 □ No
OI V	this ce al direc	To B	1 Yes 2 No		R/Outpatien		4 Li Nui Sing Fi			☐Other (Spe	cify)
ding	n. After funer	tion:	27. Manner a Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred /	
Atten	er deat rector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (. City or Tol	Street and wn. State)	d Number or Ru	ural Route Number,
2 pital or	urs affe eral Di lled in			h							
To the Hospital or Attending Physician:	within 24 nours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	edical		sician: To the best of my know ner: On the basis of examination and manner stated.							
Toth	To the	Me	29b. Signature and title of certifler	1 .		29c. Licens	e number		29d. Date	e signed (Mont	h, Day, Year)
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	8		30. Name and address of person who co	inpleted cause of death (Item 2	saj (Type,	kus Be	zyvar be	e) Cor	Ba	1 m, 41	> 21224
* y	Sta		31. Date filed (Month, Day, Year) MAR 1 1	32. Resistrar's Signatu		hack			,		
	Registi	rar	MHV TT 2	TOOL TOOLS	~ /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01824 State of Maryland / Department of Health and Mental Hygiene Bobby Ray Lerma amend #20c Per FH G87 Celtificate 8f DHath Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day March 4, 2008 Year 1128 hrs Bobby Lerma Ray Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Upper Chesapeake Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 451–77–8037 If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthdav) 6 Sex **Funeral** Months Davs Hours Min. 24 04/23/1983 TX Director 1 XM 2 F ۷rs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County Aberdeen Proving Ground Yes 2 X No Hartford MD 28a-f show 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number USA 21005 Bldg. E 4227 Edgewood Avenue "natural", or items 23a or 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married 1 X Yes White f Yes, Give Year U.S. Army 1 Yes 2 No specify: Specify: 3 Widowed Divorced 4 ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Soldier U.S. Army Baltimore, MD 21215-0036 If item 27 is marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angie Moya Robert Lerma event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 4457 Arthur Lane, College Station, TX 77845 Angie Moya / Mother t. Pages I and 2 st tment of Health an rtant: If item 27 y or other trauma 20c. Location - City or Town, State 20h Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Vavasota Vovasota, 1 X Burial 2 Cremation 3 Removal from State 3/13/2008 Oakland Cemetery Donation 5 Other Specify: Address of Facility ries L. Stevens Funeral Home Inc. I East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death Combined Drugs (Morphine, Codeine, and Alprazolam) Intoxication immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ian/Medical X UNPENDED AMENDED 23a, 27, 28a-f per ME g878 4/2/08 amh attending physician for use as the burial -The law requires that the death certificate be Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) Physici 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has performed 2 No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: '24 hours after death. 25. Was case referred to medical Division of Vital Be examiner? Other; Hospital: 1 Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 After this 1 Yes funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: 1 Natural Yes 2XX No Pending Director: the Found 10:00am Found 3/4/08 Unknown. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.
Found in domittory room on Army base 28f. Location (Street and Number of Rural Route Number, City or Town, State Building E 4227 Rm. 127—B Abendon Towns III Cloud Communication of the Communica 3 6 X Could not be Suicide 24 hours a Provide Grounds. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 **Medical** within 2. To the F 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 5, 2008 O.C.M.E. no 30. Name and address of person who completed cause of death (item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Benjamin Franklin Lindsay 5;06 a.™ March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore n/a FutureCare-Lochern 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1√2 M 2□ F 267-62-4890 64 Director Feb. 10, 1944 FI. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1√2 Yes 2 □ No Baltimore n/a Director M) 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 4800 Seton Drive 21215 within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify. African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MIA 8th Bus Driver permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other 1 any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jonah Lindsav Irene Thamas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7611 Lilly Avenue, Severn, MD 21144 Sherise L. Lindsay/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 3-8-08 Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final disease or condition resulting in death) Theros deron i disease Physician pelsouse alar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 HInknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Dunktown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 2[25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymona Miller Smli 200 25 Main Smet MD 21136 strar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 8, 2008 10:30 AM Mary Lou Maurer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nightingale House Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 160-22-1173 Director 81 July 2, 1926 Pennsylvania Usual Residence of Decedent a or 28a-f show be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Poolesville Maryland Montgomery filed within 72 hours after death with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20837 17004 Spates Hill Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item edical Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Good Year Tire Co. Secretary 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any finiry or other traumatic event once. Be Frank V. Fodell Bessie Gordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hept (Neice) 17004 Spates Hill Rd., Poolesville, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Mt. Lebanon Cemetery | 3/15/08 Mt. Lebanon, PA 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
L. Beinhauer & Son Co. 21. Sign Ture of Puneral Service Lipense 2630 West Liberty Ave., Pittsburgh, PA 15216 Lannes Ellmi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Possible Gastrointestinal Malignancy Completed Anemia 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s has autopsy performed? Yes 2 X No certificate Chronic Obstructive Pulmonary Disease 1□ Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) iving Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide in 24 hours.
the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely To the within 2 and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 10, 2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 11 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 ⁷ 08^{Year} Month 3 **Physician** 1041 Algernon McGriff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hosp. Montgomery Silver Springs Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 579-52-7278 Director 70 5/20/37 Wash.,DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Montgomery Silver Springs 1 ☐ Yes 2√2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2606 Bel Pre Road 20906 USA Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: American ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer d 2 should be filed w th and Mental Hygies 7 Is marked other th 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Richard McGriff Evelyn Robinson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Izola Ancar/Sister 3325 29th Avenue, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crem. 3/10/08 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Furniral Service Licensee <u>5126 Belair Rd, MD 21206</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car, ac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician IABI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: nse . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2□No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: the Hospital or Attending 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Montgomery General Hospital

Silver Springs ,MD 20910

つま

31. Date filed (Month, Day, Year)

Sadik M. Ali

Name and address of person who completed cause of death (Item 23a) (Type, Print)

A 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 6:00 3 7 2008 Eugene Myers, Sr Walter /Medical 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 249-58-8599 1 X M 2 □ F Director 68 11-9-1939 S.C. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at **X**Xes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 21213 2001 E. Lanvale Street USA Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ No Specify. ģ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Firestone Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Simmons Moses Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 E. Lanvale Street Balto, MD 21213 Lizzie Myers-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State p☐purial 2 ☐ Cremation 3 ☐ Removal from State 3-14-2008 King Memorial Pk Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East Glady w one 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final multiple organ system failure Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sepsis Sequentially list conditions. Due to (or all a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 1 No Physiclan: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\sum \) Nursing Home Hospice 1 ☐ Yes 2 ☐ No 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

150 MD

Maryland 21215-0036

Baltimore,

or Vital

Division

N Eutaw St

Baltimore MD

4b. City, Town, or Location of Death

COLUMBIA

MACDANIEL

2. Date of Death Month MAR

3. Time of Death

10:54 PM

200B

HUWARD

4c. County of Death

Physician

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

ALLEN

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GONERAL INDSPITAL

	Funeral Director		5. Social Security Number 212-26-1657	6. Sex 1 X M 2 ☐ F	Age (In yrs. last bir 77	Yrs. If Under Months	1 Year Days	Hours Min.	8. Date of Bir (Month, Date Aug. 29	th ay, Year) 9. 1930	9. Birthplace (State or F Country) Maryland	oreign
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	<u>-</u>	Usual Residence of Decedent 10a. State 10b. County MD Ra11		10c. City, Town						10d. Inside City I	
	the M 28a-f notifie	recto	10e. Street and Number	timore		Balti 10f. Zip		2		10g. Citizen	of What Country?	X
	ath with 23a or ust be	Funeral Director	5717 Oakland E					.227			States	
	fter de	Fune	11. Marital Status 1 □ Never Married 2X Marri	12. Was Decedor Armed Force ied 1 X Yes 2	es? □ No			panic Origin? (S , Mexican, Puert	pecify Yes or No o Rican, etc.))- 14. F	Race - American Indian, Black, White, etc.	
2-003p	ural", o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:	1 ☐ Yes 2		Specify:			white	
7	nin 72 h n "natu Medica	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			Give kind of work life. DO NOT use	l Occupa k done du e retired)	tion uring most of wor	king	Defe	f Business/Industry	
7	led with tygiene her tha ht, the I	Com	12			<u> Telecomm</u>		ator 18. Mother's Nam	no /Eirot Middle	Maidan Sun	Industry	
<u>a</u>	ild be fi tental H ked ot Ic ever	To Be	17. Father's Name (First, Middle, Lawrence MacDa						de Wiess		iame)	
nary	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if the Ather and Mental Hygiene items 23a or 28a-f show titem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations					nd Number or Ru	ıral Route Numb	er, City or To	wn, State, Zip Code)	
<u>5</u>	s 1 and f Health item 27 other tr		Sandra J. Vale 20a. Method of Disposition		aughter 20b. Place of	Disposition (Nam ry, crematory or ot eran Cem	e of	d Road,	Date		on - City or Town, State	
Daltillinor	Page ment o ant: If lury or	1	1 Surial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from St pecify)	ate MD Vet	éran Cem	eter	у 3 - 6-	-2008	Crown	sville, MD	
סמו	permit. Pages 1 and Department of Healtmoortant: If item 2 any Injury or other once.		21. Signature of Funeral Service	Licensee	OAC	1328 S	a Address	of Facility An	nbrose F	uneral	sville, MD Home, Inc. s, MD 21227	
1	1	1	art1. Enter the disease, or shock, or heart failure. List	complications that cau	used the death. Do not hime.	not enter the mode	of dying	, such as cardia	or respiratory a	rrest,	Approximate Interval Betwe	en
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_aSi	EPTIC S	HUCK					Onset and Dea	
	Examiner		Constalled the sensitivity		as a consequence						7 DAY	ς
	sit W te	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	of):						
5	execu an and rrial-tra		that initiated events resulting in death) Last	c Due to (or	as a consequence	of):						
00/00	icate be physici s the bu	dical		d								
. DOX	requires that the death certificate be executed een signed by the attending physician and could be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birt	ome pf pregnancy th 2 Fetal death nt at time of death	3 ☐ Ectopic pre				23d.	Date of delivery Month Day Yea	ar
5	that the ed by th detache	Phys	9 ☐ Unknown Part II. Other significant condition			the underlying ca	use aiver	n in Part I.	23e. Did	tobacco use c	contribute to the cause of dea	ith?
, S	quires 1	ted by		CARDIAR I							o 3[XProbably 4 □Unk	
	≥ Q ts	Complet	AUTS PEN	VAZ RAILI	126				24a. Was	an 24	tb. Were autopsy findings ava prior to completion of caus	ailable se of
ğ	an: The tificate or, pag	e Cor	1473275NG.		DIA	NOTES N		コマンS 26. Place of Dea		ormed? 2 X No	death? 1 ☐ Yes 2 ☑ No	
5	hysici this cer il direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 📉 np	oatient 2 ER/Ou		A Other	r: 4 ☐ Nursing H	lome 5 ☐ Resi	idence 6 🗆		
5	ding P	tion:	27. Manner of Death 1 ☼Natural 5 ☐ Pending 2 ☐ Accident investig	9		Time of 28 njury M	8c. Injury Work? 1 □ Y	at ? es 2∐No	28d. Describe	how injury oc	curred	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	f injury - At home, fa , etc. <i>(Specify)</i>	rm, street, factory,	, office	- 27	28f. Location (City or To	Street and Nu wn, State)	ımber or Rural Route Numbe	r,
	ne Hospita 24 hours ne Funera stetety fille	Medical C		g Physician: To the be Examiner: On the bas and manne	is of examination an						manner as stated. ce, and due to the cause(s)	
	To the transfer of the transfer of the transfer of tra	M	29b. Signature end title of certifier	llyangs	~~		License D36	number 974			gned (Month, Day, Year) - Z フットを	
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	Sta Registr		31. Date filed (Month, Day, Year)	2008	gistrar's Signature	Breek)						
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State of Maryland / Department of Health and Mental Hygiene UU 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C **Physician** Albert Gerard Moran /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita Year | If Under 24 Hrs. comarita (5. Social Security Number N/A 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 9. Birthplace (State or Foreign Days Hours MAN 2□F 83 213-18-6870 Yrs. Director Feb. 16, 1920 Baltimore, MD Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore County Maryland Director Parkville 1 ☐ Yes 2☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1731 Edgewood Road 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ②Mes 2 □ No If Yes, Give W.W.II Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0. 1 ☐ Yes ŽŒNo Specify White eted by Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) N/N 11 Mechinist American Can Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar Moran Pearl Ballance 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortant: If item 27 Is injury or other trau Mrs.Bettie Charleen (nee McLuckie) Moran 1731 Edgewood Road Parkville MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Entombinent Dulancy Valley Mem. March 10, Timonium, Maryland Peacerul Marternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 23a. Part 1 Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician a Hypertensive atheros Clarotic Cardio Vascular discore /Medical bue to (or as a consequence of): Examiner uputensi a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of) executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the burial equires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Abdominal antic anemysm 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No of Vital 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Atlending Division 5 Pending d ath. 1 ☐ Yes 2 ☐ No investigation M after dath 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number march, 5, D0062735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rowen Blud, Bultimore, MD 21239 Aparna Jonnal 5601 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAR 11 2008 Registrar

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permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medione.		Georgianna Manson /	Daughter	4 Ret	inue Cour	t. Woodla	wn. Mar	vland	21207
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of m On the basis of exa and manner stated.	y knowledge, deat amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Merbach Sr. March 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Morning Side House of Friendship Anne Arundel Hanover If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 15,1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 X M 2 □ F 220-03-9697 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If lem 27 is marked other than "natural" or items 27 is marked other than "natural" or items 2000 market than 10a. State 10b. County 10c. City. Town or Location Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 South Drew Street 21224 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Self Employed Tire Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Gustav Ada Merson 2 19a. Informant's Name/Relationship (Type. Print) Carol Wade Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition cemetery, crematory or other place)
Holy Redeemer Cemetery March 14. X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 Donation 5 Dother (Specify) 21. Signature of Furneral Service License 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or such line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical e to (or as a consequence of) **Examiner** Examiner Due to (or as a consequence of)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 968 Oakdale Circle, Millersville, MD. 21108 20c. Location - City or Town, State Baltimore, MD. 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Opset and Death Liouastulan Discare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No 2 E 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) suste 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 11410 □Hatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier and manner stated. 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellip 32. Registrar's Signature 31. Date filed (Month, Day, Year)

4:00

9. Birthplace (State or Foreign Country) Maryland

14. Race - American Indian Black, White, etc.

Specify:

White

10d, Inside City Limits 1 TXYes 2 □ No

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The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician as the the signed by t certificate To the Hospital or Attending Physician: this After i Director: within 24 hours a To the Funeral [

> State Registrar

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2008

1 - For State Registrar

10a. State

Mary1and

10e. Street and Number

5. Social Security Number

223 24 3600

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

10b. County

Glen Burnie Health & Rehab.

6. Sex

1⊠M 2□F

Anne Arundel

Weldon M. Morris

7. Age (In yrs. last birthday)

10c. City, Town or Location

Baltimore

85

	be filed within 72 hours after death with thy diene, diether than "natural", or items 23a or event, the Medical Examiner must be r	ä	Toe. Sileet and Number			Tor. Zip Code			Tug. Citi	zen of what C	country?
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	lo the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu		29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								o otolod
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	F 3 F 8		14.0					MARCH 7, 2008 2106/ BURN FE, MARYLYND			
,	Y	30. Name and address of person who completed cause of death (Item 23a) (T				D/499/					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

10f. Zip Code

4b. City, Town, or Location of Death

Glen Burnie

If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. |

Reg. No.

4

Day

Year

Anne Arundel

2008

4c. County of Death

10g. Citizen of What Country?

5:30 A.

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 X No

Virginia

2. Date of Death

8. Date of Birth (Month, Day, Year)

03/03/1923

March

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. **Physician** /Medical Examiner

Funeral

Director

If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, certificate | within 24 hours after death.

To the Funeral Director; Af

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O8 1941 **Physician** MUTH EDWARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AnneArundel Linthicum Hospice House Linthicum 8. Date of Birth (Month, Day, Y Sept. 28 Birthplace (State or Foreign Country)
 AD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 69 MD 217-38-1000 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-f show may injury or other traumatic event, the Modical Experiment outsibe notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 **USA** 907 Lombardee Circle 12. Was Oecedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tile Company 0wner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian 0'Donnell Edward Muth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (spouse) 907 Lombardee Circle, Glen Burnie, MD 21060 Rita W. Muth 20c. Location - City or Town, State 20a. Method of Oisposition **Physician** /Medical Examiner

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: completely filled in by the

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Loudon Park Cemetery 2008 Baltimore, Marylar										
	21. Signature of Funeral Service License	Itallen.		and Address of Facility S 1 Mountain Ro	tallings F ad, Pasade					
dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each little. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.									
	resulting in death) Last	Due to (or as a conseq								
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of del Month	delivery Day Year							
Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 F									
		prior to death?	utopsy findings available completion of cause of							
Be	25. Was case referred to medical examiner?				ath (Check only one)		ATE			
2	1 Yes No	fospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	OOA Other: 4 Nursing H	lome 5 Residence	6 Other (Spe	icity) HOSDICE			
atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	HOUSE			
Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the second of the s	ome, farm, street, facto y)	ory, office	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number.			
29a. Certifier (Check only one)										
Ž	29b. Signature and title/of certifier	$\langle \rangle \rangle$	2	9c. License number	29d.	29d. Date signed (Month, Day, Year)				
«	man we to	2 itams	D 2143	438 March 07, 2008						

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1

and address of person who completed cause of death (Item 23a) (Type, Print)

DEFENSE HIGHWAY ANNAPOLIS MOZIYUI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01715 State of Maryland / Department of Health and Mental Hygiene Dominique Emanuel McFadden Certificate of Death 1. For State Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Month Day February 29, 2008 Physician/ 1009 hrs Dominique E. McFadden Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Wash. Min. Months Days Hours 07-11-1981 Director 1 XM 2 F 26 579-04-9323 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1X Yes 2 No Oxon Hill Itimore, MD 21215-0036

iit. Pages I and 2 should be filed within 72 hours after death with the Maryland nument of Health and Mental Hygiene.
ortant: I filem 27 is marked other than "natural", or items 23a or 28a-f show ry or other transatic event, the Medical Examiner must be notified at once. PG MD 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA 20745 829 Marcy Ave. Apt#104 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nouneral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married X No Yes Specify:Black Yes 2 X No specify. If Yes. Give Year Divorced ð 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted Elementary/Secondary (0-12) College (1-4 or 5+) Private Landscaper 11th Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Green McFadden Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marcy Ave. #104 Oxon Hill, MD 20745 Rose Green/ Mother 829 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Washington, DC ₩Surial 2 Cremation 3 Removal from State 03/07/08 Glenwood Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility Conald Taylor II Funeral Hm. Signature of Funeral Service Licens 21201 108 West North Ave.Baltimore,MD Approximate Interval cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or comp Between Onset and Physician failure. List only one cause on each line. Death Medical a. Gunshot Wound of Torso Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical **AMENDED** the attending physician ed for use as the burial -UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy death? performed? this certificate has 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Division of Vital Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 2 CER/Outpatient 3 DOA Inpatient 1 🗸 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After t 27. Manner of Death Subject shot by security guard Certification: Feb 29. 2008 0909 hrs 1 Yes 2 ✓ No Natura Director: Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1001 Marcy Avenue, Oxon Hill, MD Could not be Suicide determined (Specify) Other (apartment grounds) 4 V Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 1, 2008 O.C.M.E. Mask an 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day, Year) 32. R State MAR Registra

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Registrar

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AFIND TIEM/IDe, perFH C8/7, 3/18/08 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MORTH RCHDay **Physician** 2008 JAMES THOMAS NORRIS 6:03 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 X M 2 □ F 215-34-5142 Usual Residence of Decedent Director May 10, 1937 Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. Cify. Town or Location 10a. State 10b. County ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Stor 10f. Zip Code 10e. Street and Number Shire 10g. Citizen of What Country? 2104 SF Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. \$ 3 ☐ Widowed 4 ☐ Divorced white Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gas ? permit. Pages 1 and 2 should be filed witt Department of Health and Mental Hygiene Important: If Item 27 Is marked other that any hijury or other traumatic event; the once. station owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) ပ္ manda Momoson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) ourt Fallston MD 21047 Norris Janet Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Hamorial Gardens 3/12/2008 Follston, M 22. Name and Address of Facility Eucins Funeral Chapel + Cremation Services 3/12/2008 Fallston, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Forest Hill Marylanda10 3 Newport Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician COMPLETE HEART BLOCK /Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed CORONARY ARTERY DISEASE physician and s the burial-tren Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9∐Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown DIABETES 1 Yes Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an his certificate has bil director, page 2 sh autopsy performe 2 No 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Tyes 2 ER/Outpatient 3 DOA this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours a Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -10-02 my NCIL DB1826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM TOWSON, MARYLAND 21204 M. D. 7691 OSLER DRIVE istrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

MAR 11

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amend item 1 per ind 8877 3-14-08 yt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nowowie jski Adrienne Dav 1215 PM **Physician** OWOW ie March 2008 /Medical 4b. City, 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (Month, Day, Year)
12-3-1960 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Maryland Director 76-2738 e of Decedent 6 -Il Residence 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Yes 2 No **Funeral Director** Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21224 Street 3118 O'Donnell 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Photography Photographer 18. Mother's Name (First, Middle, Maiden Surname) Lorraine Virginia Long 17. Father's Name (First, Middle, Last) Henry Joseph Nowowiejski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3118 O'Donnell Street Baltimore MD 21224 Health em 27 i Nowowiejski Sister Andrea other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Towson Maryland Service Corp. 3-12-2008 4 ☐ Donation 5 ☐ Other (Specify) Hilltop 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 21. Signature of Funeral Service Licensee Inc. 7922 Wise Ave Dundalk MD 21222 Approximate Interval Between Onset and Death 2 days art1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Intracerebral Hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it arry, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1☐Yes 2☐No 9☐Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide t Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 7 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore, MD, 21224 Anne Ruble, MD 4940 Easie 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:17 p M March 2008 LEE PATTERSON JIMMY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** APT B2 5461 CEDONIA AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days 1**XX**M 2□ F Months Hours Director 48 NORTH CAROLINA NOV. 6 1959 219-78-1650 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show 1 XYes 2 No must be notified BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 0 U.S.A. 5461 CEDONIA AVENUE APT B2 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 240 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XX Never Married 2 ☐ Married ò 1 ☐ Yes 2000 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 Widowed 4 Divorced "natural" er than "natur , the Medical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 12th grade NURSING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic ev မ WILLIE JAMES PATTERSON JOHNIE LEE TOWNSEND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah McRae/Sister 5758 MAPLEHILL RD., BALTIMORE, MARYLAND 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If Its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK 03-13-08 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Fot 1 iseas shock, or heart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MIDPAFITIC IXYEAR resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if only indicate, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine be executed Due to (or as a consequence of): physician a the burial Division or Vital Records, P.O. Box 68760. Physician/Medical 33 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page I FAUCTIVE this certificate 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 034041

State

ELLE 31. Date filed (Month, Day, Year) MAR 1 1 2008 Registrar

5601 LOCIT RAVEN BLUD BALTIMORE MY 21239 32 registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A

Thusician hoff

hown to

Name

3+1

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

A. Hashmi

Jashmi

Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month, Day, Year)

Health Care System, Perry Point, Maryland 21902

3-9-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of Maryland / D	Department o Certificate o			ene . №. ? ՌՌՋ	07022
			Registrar 1. Decedent's Name (First, Middle, Last)		- Continuato C	50411	O Data of Dooth	- CUUU	3. Time of Death
	Physicia /Medic	al	ESTELLE M. REG				Month MARCH		
)	Examin		4a. Facility Name (If not institution, give str Saint Joseph M	edical Center		n, or Location of Death TOWS			h timore
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1	7. Age (In yrs. last birt 95	thday) If Under 1 Y Months Da		8. Date of Birth (Month, Day,) Aug. 11, 1	(ear) 9. Birt 912 Bal	hplace (State or Foreign untry) TIMORE, MD.
and	Α	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
Maryl	-f sho	tor	Maryland Baltimore	County Timor	nium				1 ☐ Yes 2X No
with the	3a or 28a st be noti	Funeral Director	10e. Street and Number 12239 Roundwood Roa	d	10f. Zip Co	21093		g. Citizen of What Co United St	
J36 urs after death	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 描 Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes 2\sum_3 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	ne. nan "natura e Medical E	Be Completed	15. Decedent's Educa (Specify only highest grade	ttion 16a. College (1-4or 5+)	Decedent's Usual O (Give kind of work of life. DO NOT use no HOINE Ma	ocupation one during most of work aker	sing	6b. Kind of Business	
TZ pue	ntal Hygier ed other the event, the	Be Coi	17. Father's Name (First, Middle, Last) Robert Clyde	2.7, 2.2			e (First, Middle, M Lee McLe		
Maryla od 2 should	Ith and Me 27 is mark r traumation	욘	19a. Informant's Name/Relationship (Type Mrs. Linda A. Davis			reet and Number or Ru Ridge Road	ral Route Number, New Oxi	City or Town, State, .	Zip Code) 17350
Baltimore, permit. Pages 1 ar	nt: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	cemete	of Disposition (Name of the Park of Disposition (Name of of Disposition (Na	Mem.Gard.	2008 10,	oc. Location - City or Pimonium , M	Maryland
Balti	Departm Importal any inju		21. Signature of Funeral Service License	· fair, kr.					on Ctr.,P.A.
K	9.		23a. Part Enter the disease, or complic shock, of heart failure. List only one				or respiratory arre	st,	Approximate Interval Between Onset and Death
Trans.	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		ILURE			
	xaminer		b.	ACUTE MYOCA		FARCTION			
V 3	s is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence	of):				
68760, <	physician and the burial-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				
			IF FEMALE:					Old Date of de	alivon.
O. Box 6	igned by the attending be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Volo 9 □ Unknown	Bc. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3□Ectopic preg 5□ Other (spec			23d. Date of de Month	Day Year
<u>و</u> _	signed by	by	Part II. Other significant conditions con CHRONIC OBSTRU	tributing to death but not resulting i		se given in Part I.	23e. Did tob 1 ☐ Ye		to the cause of death? Probably 4 □Unknown
Rec	has b	Completed					24a. Was ar autops perform	y prior to ned;? death?	
		Be C	25. Was case referred to medical examiner?			Other	ath (Check only on	e)	
or Vita	g: ⊵:	2	1 Yes 2 No	ospital: 1 Inpatient 2 ER/O 28a. Date of Injury 28b.		Other: 4 Nursing I Injury at Work?		ence 6 □Other (Sp ow injury occurred	pecify)
lo i	Attending Fit r death. ector; After th by the funeral	ation	1/SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
5	al or Attenta after death Director; /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, f building, etc. (Specify)	farm, street, factory,	office	28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
	lo me nospiral or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at and/or investigation, i	the time, date and place may opinion, death occ	urred at the time, d	ate and place, and d	ue to trie cause(s)
ļ	vithin 2 To the comple	Ň	29b. Signature and title of certifier		29c.	icense number	2	9d. Date signed (Mo.	nth, Day, Year)
	,		30. Name and address of person who co	impleted cause of death (Item 23a) (Type, Print)	D 37254		- (((
	Ý			M. D. 4. 7601 09	ELER DRI	VE. TOWSO	N. MARY	LAND 212	214
	St Regis	ate trar	31. Date filed (Month, Day, Year) MAR 1 1 20	32 Registrar's Signature	Grand				

			• •		elible Ink. Ensure		9	
			1 - State State Registrar		rtment of Health and tificate of Death		ene 3. No2 0 0 8	07833
	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	/Medic		Stanley J. Robinso			March	6 2008	6:26 PM
1	Examin	er	4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Dea	ıth	4c. County of Death	
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	9 Birtho	lace (State or Foreign
	Funeral Director		219-22-3944 1X M 2□F Usual Residence of Decedent	78 Yrs.	Months Days Hours Mir		rear) Couin	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Modlaal Examiner must be notitiled at	or	10a. State 10b. County N/A	10c. City, Town or Loc Baltimo			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N 28a-1 notifi	rect	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Coun	
	3a or	Funeral Director	3110 Howard Park Av	enue	21207		USA	,.
	ms 2	nera	11. Marital Status 12. Was De	cedent Ever in U.S. 13. W	L 'as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ	
9	after or ite mine	2	Armed I 1 □ Never Married 2 Married 1 □ Yes □ If Yes, 0	2 3No	Yes, specify Cuban, Mexican, Pue □ Yes 2 XNo Specify:	erto Hican, etc.)	Black, White, Afri	
93	ours iral",	d by	3 ☐ Widowed 4 ☐ Divorced Year or	Dates:	Lites Zizzino Opeciny.		Specify: Amea	rican
5-	72 h "natu	etec	15. Decedent's Education (Specify only highest grade completed	16a. Decede	ent's Usual Occupation ind of work done during most of w O NOT use retired)	orking 16	6b. Kind of Business/Inc	•
21215-0036	d within 72 hours after death with the Marylan gene. r than "natural", or items 23a or 28a-f show the Mertral Examiner must be notified at	Completed	Elementary/Secondary (0-12) College	(1-40r 5+)	ineer		City of	Bait.
p	be filed tal Hygied of other event, the	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Ma	aiden Surname)	
ylaı	should be filed vind Mental Hygie marked other t umatic event, th	70	Stanley Robinsor	, Sr.	Estel:	le Robins	son	
Maryland	nd 2 should Lith and Ment 1th and Ment 27 is marked r traumatic e		19a. Informant's Name/Relationship (Type. Print)	1	Address (Street and Number or I Howard Park			
ďΣ	Be ee a		Elva Robinson/wife 20a. Method of Disposition	20b. Place of Dispos			Oc. Location - City or To	
mor	Pages ent of nt: If it ry or c		1 XBurial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	state King Me	atory or other place) 3/1 morial PK	2 ^{Date} 08	alt. Coun	ty, MD
Baltimore,	permit. Pages I Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service License	22.	Name and Address of Facility H 26 Belair Rd,	ari P. C	lose F. S	vs, PA
-	*		23a. Part1. Enter the disease, or complications that	caused the death. Do not ente				Approximate
	Physician	85 9	shock, or heart failure. List only one cause on Immediate Cause (Final		- 1	Interval Between Onset and Death		
	/Medical		disease or condition resulting in death) aa.	Myocard:al o (or as a consequence of):	Interction			
	Examiner		Sequentially list conditions, b.				-	
	p #	iner	if any, leading to immediate Due to cause. Enter Underlying	o (or as a consequence of):				
(A)	xecuted and Il-transit	xamine	Cause (Disease or Injury that initiated events resulting in death) Last	(
60,	9. ⊒ 6	ш	Due to	o (or as a consequence of):				
68760	icate be ey physician s the buria	dic	d					
Box (eath certific attending p I for use as 1	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, o	utcome pf pregnancy			23d. Date of delive	arv.
ğ	requires that the death certificate be een signed by the attending physicis hould be detached for use as the bu	Physician/Medical	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
P.0	at the de by the	hys	9 □ Unknown 9 □ Unk	nown				
	res tha igned b	by P	Part II. Other significant conditions contributing to				acco use contribute to the	ne cause of death?
ord	w require been sig should b	edi	Hypertension			1 ☐ Yes	s 2 No 3 Prob	ably 4 Tonknown
Division or Vital Records,	law as b	Completed	Hyper lipidem	ام		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u> </u>		Com	,, .			penonin	ed? death? ☑No 1 ☐ Yes	
Vita	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			eath (Check only one,)	
or	ys di is	은		Inpatient 2 ER/Outpatient e of Injury 28b, Time of			ice 6 Other (Specif	y)
n	ding I. After funer	ion	1 ☑Natural 5 ☐ Pending (Mo	e of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	vinjury occurred	
isi	Attending r death. ector; After y the fune	licat	3 Suicide 6 Could not be 28e Plac	ee of injury - At home, farm, stre		28f. Location (Stre	eet and Number or Rura	al Route Number.
<u>S</u>	all or / after I Dire d in b	Certification:	4 Homicide determined buil	ding, etc. (Specify)	,	City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	(Check only 2 Medical Examiner: On the	ne best of my knowledge, death basis of examination and/or inv	occurred at the time, date and pla estigation, in my opinion, death oc	ce, and due to the car curred at the time, da	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	To the within 2. To the Complet	Mec	29b. Signature and title of certifier	inio sauco.	29c. License number	29	d. Date signed (Month,	Day, Year)
				Μ.Δ.	D59062		March 6, 2	2008
	1		30. Name and address of person who completed car	use of death (Item 23a) (Type, P	rint)			
	1 \		Chad Hansen, M. O.	2401 W Belved	ere Baltimore	MA 2/2/5		
67	Sta		30. Name and address of person who completed care CL-d H-nsen, M.A. 31. Date filed (Month, Day, Year) MAR 1 1 2008	Registrar's Signature	A Comment			
	Registr	aı	MAR I I ZUUO	The same of				

DHMH 17 Rev 1/2001

MAR 1 1 2008

08-01898 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Fer FH G87/ Department of Health and Mental Hygiene Tiffany Ruffin 2008 07834 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 7, 2008 1202 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) NIA Baltimore University Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Min Director Country) A _M 2XF Yrs 4NKNOWN Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No N)/ Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 X Never Married 2 2 X No Yes If Yes, Give Year 1 Yes 2 No specify: Specify: 3 Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) d other than "i of Health and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked Be NTON (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ 19a, Informant's Name/Relationship (Type, Print) If item 27 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition filmore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State portant: Donation 5 Other Specify 21. atur of er I Service Licensee NAVE TO Port). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease a. Complications of upper respiratory infection xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ted for use as the burial - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED23a,27 per ME g878 4/10/08 amh Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? signed by t be detache contributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions Ö 1 Yes 2 No 3 Probably 4 V Unknown Completed by ۵. Records, icate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Division of Vital Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 X Natural Yes 2 No Pendina within 24 hours after death. the To the Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) filled determined (Specify) Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 8, 2008 O.C.M.E. wir tor she 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

2008 OCME

Assistant Medical Examiner

Tasha Greenberg MD.

MAR

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NSOM 2008 Mar /Medical Facility Name (If not institution, give street 4c. County of Peath 4b. City Town, or Location of Death and number **Examiner** andallstown Wes 492 MITAI Center TIMOVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 🏌 □ F 78 213-30-6233 Director 11-3-1929 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Gywnn Oak Baltimore MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3107 Woodford Place, Apt. B 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int; if Item 27 is marked other than "natural", or itel 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: African American <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Spring Grove State Hospital Elementary/Secondary (0-12) College (1-4or 5+) Pratical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leathia Jones Beverly Gates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Robert Lewis Avenue, Upper Malboro, MD 20774 LaFerne E. Johnson/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important; if Ite
any injury or of ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Łoudon Park Cemetery 3-14-08 Baltimore, MD Sign June of Funeral Service Licenses 22. Name and Address of Facility Wylie Fineral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transi or Attending Physician: The law requires that the death certificate be execu Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 1∏ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: ို 1 ☐ Yes 2 No 1 🗀 Inpatient this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 TYes 2 TNo s after death. 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D To the Hospitai Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification cause of death (Item 23a) (Type, Print) 1 and address Did ton ICLA

Projetrar's Signature

32.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 0.0.0.

			1 - For State Registrar	State of Ma	iryianu /		tificate			rental Hy	/gien Reg. N	2000	3 0/836
I	Physici	an	1. Decedent's Name (First, Middle, La	•			-			2. Date of De Month			3. Time of Death
	/Media	al	WILLIAM ADAM R							MARCH	6, 2	8002	12:00 P M
-	Examir	er	4a. Facility Name (If not institution, given 1402 Cottle Cou	·			Jopp.		cation of Death			c. County of De Iarford	eath
	Funeral		Social Security Number 6.5	Sex 7. Age	(In yrs. last t	birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Bi	rth		irthplace (State or Foreign Country)
	Director		217-21-8922	K □M 2□F	19	Yrs.	Months I	Days F	Hours Min.	Sept.	14,	1988 Ma	aryland
	ow or		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Mary B-1 eh	to	Maryland Harford		Joppa	a.							1
	or 28	Directo	10e. Street and Number				10f. Zip C	ode			10g. C	itizen of What (Country?
	s 23a		1402 Cottle Cour				210				USA		
0	hours after deeth with the Maryland ural', or Items 23a or 28s-1 show at Examinar must be rediffied at	Funerai	11. Marital Status 1 ∑Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N		1			anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Hace - An Black, Wh	nerican Indian, nite, etc.
ž	ral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	∏Yes 25	No S	Specify:			Specify:	White
7	"natu	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	a. Deced (Give	lent's Usual (Occupation done durin	n ng most of work	ing	16b. I	Kind of Busines	ss/Industry
9500-91212	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		Worke						
	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)	1 1	AGAGT	VIOLNO		Mother's Name	e (First, Middle	, Maide	n Sumame)	
yland	Menta	To E	William Anthony	Rattman				F	Taith Su	san Di	cker	son	
Mar	12 sh h and 7 is m		19a. Informant's Name/Relationship (•					Number or Run	al Route Numb	er, City	or Town, State	, Zip Code)
	Healt Healt tem 2		Sue Rattman / Mot 20a. Method of Disposition	ther	20b. Place	.402 of Dispos	Cottle sition (Name natory or othe	e Cou	rt. Jos	pa, MD	210 20c. t	85 ocation - City o	or Town, State
Ē	Pages nent of nt: If i		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1	-	•		m 3-11	08		son, Ma	
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow ampting or other treumatic event, the Medical Examinat must be notified at an ance.			4 Donation 5 Other (Specify) Hilltop Service Corp. 3 1. Signature of Funeral Service Licensee MCComas Funeral 1317 Cokesbury								SOII, FE	путана
	205 2 3		Augus Ul	lugh			31/C	okesb	urv Roa	d, Abii	nado	n, MD 2	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e .					or respiratory a	irrest,		Approximate Interval Between Onset and Death
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	Examiner		Sequentially list conditions	b. H	24m		syndri	ort.					19 years
	हें द्वा	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	e of):	1						
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08/00,	ysicieu	edical	(d									
			IF FEMALE:										
o D	ath cer ettendir for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2	2 ☐ Fetal deat		Ectopic preg	nancy				23d. Date of d	elivery Day Year
j.	w requires that the death cert been signed by the ettendin should be detached for use	Physician/N	1 Yes 2 No 9 Unknown	4□Pregnant at t 9□Unknown	ime or death	5 🗆	Other (speci	rfy)	-				
r.	as thet	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the un	derlying cau	se given in	Part I.	23e. Did 1	tobacco	use contribute	to the cause of death?
cords,	equire	ted								10	Yes 2	125No 3□1	Probabły 4 ∐Unknown
2	e 2 sh	Completed								24a. Was	psy	24b. Were a	autopsy findings available completion of cause of
V II a	n: Th ficete or, pag	e Co	DE Management and the second as							1 ☐ Yes	2 S-N	death?	es 20 No Mit
5	y sicia s certi directo	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/O)utnatient	3□ DOA	Other	 Place of Death Nursing Ho 			6 □Other (So	nacihi)
5	ding Physicien: The lav h. After this certificete hes funeral director, page 2.	L L	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day	28b.	Time of Injury		Injury at Work?		28d. Describe			SUNY
VISIOI	tendli death. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	1			М	1 🗌 Yes	2 □ No				
<u> </u>	after of Direction by	Certification:	4 Homicide determined		ry - At home, f (Specify)	farm, stre	et, factory, o	office		28f. Location (City or To	Street a wn, Stat	nd Number or I e)	Rural Route Number,
			29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	ysicien: To the best of niner: On the basis of	my knowledg	ge, death	occurred at t	the time, d	date and place,	and due to the	cause(s	and manner a	as stated.
	ithin 2, or the lomplet	Medicai	one) 29b. Signature and title of certifier	and manner stat	ed.			icense nu		00 41 110 14110,		ite signed (Mor	
	F 3 F 8) Anax	1	W)								
	6		30. Name and addr - s of person who		ath (Item 23a)) (Type, P	Print)	0	01	1	7	20000	emo 21093
97	Sta	0	7-40	0 () - (.)	r's Signature	045	5 rail	115	KO F	NH 560	(1)	Hervil	61VVD 51002
	Registra		MAR 1 1 20	08 38. Registrar	, 1	100							

DHMH 17 Rev 172001

State Registrar

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral I

completely filled

death with the Maryland

altimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

M USDATUS Year) 31. Date filed (Month, Day, MAR 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

29b. Signature and title of certifier

LED Atus



ORIGINAL.

29c. License number

D47934

BAUTMONE

29d. Date signed (Month, Day, Year)

66

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 14 per fb 877 3-11-08 yr State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ø M James William Sims-El, Jr 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner maryland General Stimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year)
7-25-1945 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 62 212-46-9321
Usual Residence of Decedent Director MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 √Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1316 E.33rd Street Funeral 21218 S A

14. Race - American Indian,
Black, White, etc. death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ∏Yes 2 ∏ No If **X**es, Give Year or Dates: 1 ☐ Never Married 2√2 Married 1 ☐ Yes 2 🛛 No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Motors 12th grade College B.S Inspector Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James William Sims, Lucinda Nobel ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health a Important: If item 27 is any injury or other trauonce. Zattura Sims- El - Wife 1316 E. 33rd Street Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-10-2008 Balto, MD Greenmount Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 1101 E. North Avenue Balto, MD21202 mis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemodynamic Physician /Medical Que to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown rate nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	arylan		artment of I rtificate of		d Mental Hy	ygien Reg. N	21118	07840
	Physici		1. Decedent's Name (First, Middle,	Carolyr	n Mi	chel	le Smit	h	2. Date of D Month 3		Day Year 2008	3. Time of Death 10:05 a ^M
	/Medio		4a. Facility Name (If not institution,				4b. City, Town, o		eath	4	4c. County of Death	
			Gilchrist Cen				Towson				Balto	
	Funeral			5. Sex 7. Ag 1 □ M 2 🔀 F		last birthday) Yrs.	If Under 1 Year Months Days		lin (Month, E	Dav. Yea	(Cou	place (State or Foreign ntry)
	Director		216-62-7441 Usual Residence of Decedent		50	113.			12-	19-	1957	MD
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
	Mary Ffsh fled	to	MD N/A		Bal	Ltimo	re					1 DXYes 2 □ No
	th the	irec	10e. Street and Number		, Das	L C ZINO	10f. Zip Code			10g. 0	Citizen of What Cou	ntry?
	th will	Funeral Director	2236 Cecil Av				21218				USA	
	r dez tems	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? oan, Mexican, Pi	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Ameri Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene, when than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Ž.	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2☐ If Yes, Give Year or Dates:	No		1 ☐ Yes 2 📉 No	Specify:			Specify: Bl	ack
21215-0036	72 hours "natural";	Completed by	15. Decedent's			16a. Dece	dent's Usual Occu	pation		16b.	Kind of Business/Ir	ndustry
75	nin 72 In "na Medik	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give	kind of work done DO NOT use retire	during most of ed)	working	ט	J. S. Po	stal
2,5	d with giene gr tha	ĕ	12th grade	2 Years		M	ail Car	rier			Servic	e
Pu	al Hy d oth	Be	17. Father's Name (First, Middle, La	ast)					Name (First, Middl	le, Maid	len Surname)	
<u>8</u>	ould the Ment arked	P.	James Smith			1		Alean				
2	12 sh h and ris m		19a. Informant's Name/Relationshi		or		ng Address <i>(Stree</i> : 6 Cecil				y or Town, State, Zi ID 21218	p Code)
٥	1 and Health		20a. Method of Disposition	.ns-baugn			osition (Name of matory or other pla		Date	<u>.</u>	Location - City or T	own, State
Baltimore Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical lonce.		Walled of Disposition (Burial 2 □ Cremation (4 □ Donation 5 □ Other (Spe	B □Removal from State	, IZ i v		<i>matory</i> or other pla morial		_13_200		•	stown, MD
=	artme artme ortani Injun		21. Signature of Funeral Service Li		IVII		2. Name and Addr		March			SCOWITY IID
ä	Dep Dep ouc		1 Brukmin			11.	1101 E	. Nort	h Avenu			D 21202
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the deatl	h. Do not en	ter the mode of dy	ing, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Been	57/	PANIOR	R WM	BRAIN	1 META	STA	515	Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a conseq	uence of):	A Will	0,000		J. 77	<u> </u>	acce
Ę.	Examiner		Sequentially list conditions,	b								
	B()/5	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence off.						
	xecut	xar	that initiated events resulting in death) Last	c Due to (or as	в а сопѕед	uence of):				-		
10°5 10°5 68760	ificate be executed graphysician and stransit transit	alE										
10,0	tificate ig phys as the	edical	179	d								
×		M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			⊒Ectopic pregnanc	24			23d. Date of deliv	
yn 314/08	law requires that the death certifies is been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗷 No	4☐Pregnant a			Other (specify)	у,		-	Month	Day Year
) o	w requires that the d been signed by the should be detached	Phy	9 ☐ Unknown					in Don't	220 Die	d tobooo	o usa santributa ta	the cause of death?
3	ires th	by	Part II. Other significant condition	is contributing to death t	out not res	ulling in the t	muenying cause gi	ven in Fait i.		∃Yes		bably 4 □Unknown
~ 5	requi	Completed							- 1			
	g i e	mpl								as an topsy rformed	prior to c death?	topsy findings available ompletion of cause of
100	sician: The certificate hi rector, page		25. Was case referred to medical					OC Place of	1 ☐ Yes		No 1 □Yes	2 □ No
Carelyn Vital Reco	Physician: r this certifica ral director, p	o Be	examiner? 1 Yes 2 No	Hospital:	ient 2 🗆	ER/Outpatie	nt 3□ DOA Ot				e 6 Other (Spec	ity HOSPICE
	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Inj	ury	28b. Time o					njury occurred	
7 5	Attending F r death. ector: After by the funera	atio	Natural 5 Pending 2 Accident investiga	tion	ay 10a1/	,,]Yes 2 □ No				
Division or Vital	r Atte ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	Zoe. Flace Ul III	jury - At ho tc. (Specif		reet, factory, office		28f. Location City or 7		t and Number or Ru tate)	ral Route Number,
Smith, Division	Hospital or 44 hours afte Funeral Dit tely filled in	Ce		<u> </u>			U		dense end dense to the		-/->	atata d
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis and manner s	of examina	wiedge, dea: ation and/or i	th occurred at the new	opinion, death	occurred at the tim	ne cause ne, date	e(s) and manner as and place, and due	to the cause(s)
	To the Hospital or Attend within 24 hours after director: To the Funeral Director: completely filled in by the it	Mec	29b. Signature and title of certifie	and marrier's			29c. Licen	se number		29d.	Date signed (Month	n, Day, Year)
	⊢ ≶ ⊢ Õ		D6	(1)/).		DA	439	5	MA	ARCH 61	2008
	1.		30. Name and address of person w	rho completed cause of	death (Iten	n 23a) (Type	Print)		- 0 -			4 4 = 11
	10		DANIEUT DEBER	MAN, MD	6565	SNO	YAPLES.	ST, 8417	7-209 E	SALT	IMUPE, M	021204
	Sta		31. Date filed (Month, Day, Year)	32. Hegist	trar's Signa	ature	E .					
	Registi	al	MAKTITO	The state of the s	-	0 1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08 0:40 PM SIBERT ALPHONSO EARL 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balli more UNIVERSITY SPECIALTY HOSPITAL Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1 X M 2 □ F Yrs. 49 Director 219-74-2547 DEC. NEW MEXICO 26 1958 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XNo MARYLAND HARFORD CO **EDGEWOOD** 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r 1925 BROOKSIDE DRIVE 21040 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade FORK LIFT DRIVER SYAMYD CO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BONEY EARL SIBERT MARY ELIZABETH SIBERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1925 Brookside Dr., Edgewood, Md., 21040 Mary E. Sibert/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State DARLINGTON, MARYLAND 4 Donation 5 Dother (Specify BERKLEY CEMETERY 03-17-08 21. Signature of Superal States 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARRFORD, beselve 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HUIN and burial-trar Due to (or as a consequence of): Cardio respirato Facture Physician/Medical as the IF FEMALE: nse s 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PCCOREL PREUMONIA 2 No 3 Probably 4 ∭ZÜnknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes XONo 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No

Box 68760, physician pe P.O. the a signed by t Records, certificate has Vital Division or

Maryland 21215-0036

Baltimore,

this After t 24 hours after death. Pruneral Director: A filled in by

within 2 State Registrar

Hospital or Attending

2 Accident 3 Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

Medical

investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D0057218 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1230 Getachew Tefferra, MD

31. Date filed (Month, Day, Year)

2008

P.O. Box 68760, Records, DWIGHT Division or Vital

signed by detail

page 2 should

certificate has

After this funeral

within 24 hours after death. To the Funeral Director: A

Hospital or Attending

Physician/Medical Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiovyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 63420 March 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake, Dr. Bel Air, MD 21014

Registrar

Lubail 31. Date filed (Month, Day, Year)

MAR 11

State Registrar

DHMH 17 Rev 1/2001

1838 GREENE TREE ROAD #300 PILESVILLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

LEUNARD RICHARDSON

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARCH 10, 2008 10:00 P M SANTA LORETTA STEUART /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8341 HILLENDALE ROAD PARKVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F 217-22-4031 Director MARYLAND 12/21/1916 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director PARKVILLE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 8341 HILLENDALE ROAD Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify \$ WHITE **X**☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME CARE HEALTH CARE 6TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be PHILOMENA LAPAGLIA NUNTIO BONANNO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. 8341 HILLENDALE ROAD BALTIMORE, MD 21234 MARY K. WOLF/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/14/2008 MORELAND MEM. PARK HILLENDALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Mama 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BrensT disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Each of Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Year 5 Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: after death. the filled in by within 24 hours at To the Funeral C completely filled

> address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

29b. Signature and title of certifie

3 Suicide

29a. Certifier

Medical

4 Homicide



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number P6053722

Good Samaritan Hosp, Baltimuse

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 3/7/08 Year Gary W. Siemer 6:02am /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 180 Meadow Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 219-62-6860 Date of Birth (Month, Day, Yea 4/16/54 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Min. 1**∑** M 2 □ F 53 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2XXNo Director Anne Arundel Pasadena 10e. Street and Number 180 Meadow Road 10f. Zip Code 10g. Citizen of What Country? 21122 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2XXIIIo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, the ones. 12 0 Longshoreman Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Siemer Mary Sarafin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene J. Klemkowski/Friend 8121 Whitescove Road, Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cem., March 11, 2008 Baltimore Maryland 4 Donation 5 Dother (Specify) Doda, Jr²² Name and Address of Facility •Charles L. Stevens Funeral Home, I 1501 E. Fort Avenue, Baltimore MD 21. Signature of Funeral Service LicenseeVictor P. UIUS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** u newl /Medical Due to for as y consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9∏Unknowr signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 ☑Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Be

Hospital or Attending Physician: The law requires that the death certificate be executed funeral director, page 2 should certificate has this After after death Director: filled in by within 24 hours a To the Funeral C

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide l 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7

State Registrar

Certification: To

31. Date filed (Month, Day,

4231

30. Name and address of person who completed cause of

MAR 1 1 2008

2. Registrar's Signature

eath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	Maryland / De	partmen ertificat				ental H	ygien Reg. N	Z 11 11	8	07846
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	Funeral	,	Riverview Nursing 5. Social Security Number 6.		Age (In yrs. last birthd			If Under	24 Hrs.	8. Date of B	irth			
	Director		219-18-6003	1□M 2ĂF	84 Yrs	Months	Days	Hours	Min.	8. Date of B (Month, D October	3,19	23 1	lary	place (State or Foreign Land
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7	()	}	20 Name and address of	completed server (death /lt co-\ C	o De:=1)	5 00	271	+1			03/0	18/	08
	4		30. Name and address of person who SERASTIAN TO	completed cause of 305		e, Print)	hu	R	oth.	~~~	MO	21	3.3	4
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	vith To	2	29b. Signature and title of certifie				29d. Date signed (Month, Day, Year) 0061480 3/10/2006 1 Baltimore MD 21236				
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	Sta Registr		31. Date filed (Month, Day, Year)		4/1/1000	086	116	121236			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕦 🗍 员 07848 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:00A [™] Shipley 03 08 2008 D. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 7848 Ridge Road Hanover Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03-10-1912 5. Social Security Number 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 95 Director 214-52-7859 Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at 1 □Yes 2X No by Funeral Director MD Anne Arundel Hanover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 7862 Ridge Road 21076 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Davis Anna Elnora Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lois Hendrix / Daughter 7848 Ridge Road Hanover, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Park 03-11-2008 4 Donation 5 Dother (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySingleton Funeral & Cremation Srv 1 2nd Avenue SW 014791 Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic **Physician** 10a15 /Medical Examiner Months ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPEdemia autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specifie) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 □ DOA residence 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760 ed by the a or Attending Physician: this After Director:

filed within 72 hours after death with the Maryland

al Hygiene.

Baltimore, Maryland 21215-0036

should be within 24 hours a

DHMH 17 Rev 1/2001

State Registrar

Medical

7845 OAKWOOD Road

29b. Signature and title of certifier

29a. Certifier

(Check only



30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOD 38912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Amend Item 24a per verb. 877:03/11/08dhb 1 - State Registral 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** February 27, 2008 8:30 PM M Orbie Stephen Sheppard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood Retirement Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**∑**M 2□F Yrs. Director 88 220-10-4756 Feb 15, 1920 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Frederick Frederick 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Willow Road 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No It Yes, Give Year or Dates: 138–40 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: white Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 conductor railroad permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Itan 27 is marked othe any lolly or other treumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Abasha Sheppard Elizabeth Ann Biser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry S. Sheppard/son 5002C Burkittsville Road Burkittsville, MD 21718 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21 Signature of Euneral Price Licensee Warder, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a-Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ۴ After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a To the Funerel C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NIMA D 16428 of death (Item 2 a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Casper E. Cline III
31. Date filed (Month, Day, Year)

MAR 1 1 2008

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

of Vital

Division

32. Registrar's Signature

mp 300 west ninth Street Frederick, md. 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No UU Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2008 4:55 A™ **Physician** Gregory P. Slater /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City 4432 Doncaster Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 15, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days New York 59 1948 Director 116-40-4259 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 USA 4432 Doncaster Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married X Married 1□Yes 2XINo Black Baltimore, Maryland 21215-0036 Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Smith Louis Slater ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4432 Doncaster Drive Ellicott City, Maryland 21043 Sandra Slater, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/08 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 ertifying Physician: To the sof my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manners stated. 29a. Certifier Medical Date signed (Menth, Day, Year) 29b. Signature 20

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0785 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:09 PM Hazel E. Stoffa MARCH 06 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE ST. AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreb 11, 1927 Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1□M 🎘 F 81 Director 186-22-5209 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 【XNo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1951 If Yes, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No <u>S</u> 1955 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hermus Goodnight Bertha Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane Catonsville, Maryland 21228 Dennis G. Stoffa, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/07/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor ^{22 Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician cances Metastalic Weeky Due to (or as a consequence of) Obstructive Pulmonary Disease years Chronic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗶 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

/Medical Examiner Box 68760. 26 U Division or Vital Records. STOFFA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

"natural"

Baltimore, Maryland 21215-0036

ral", or Items 23a or 28a-f sk Examiner must be notified

, ST-AGNES HOSPITAL MALLIKA ANGITIPALLI 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGITIPALLI, M.D.

29b. Signature and title of certifier

MALLIKA.

Registrar

29c. License number

P22257

29d. Date signed (Month, Day, Year)

06 2008

MD-21229

MARCH

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2008 3:45 A MAR Gladys Ε. Schremp /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Villa Nursing & Conv. Cntr. Catonsville Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 X F New York 1907 100 059-10-2272 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MDHoward Dayton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14190 Triadelphia Mill Road 21036 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: Baltimore, Maryland 21215-0036 White ð 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Reith Otto 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21036 14190 Triadelphia Mill Road Dayton, MD Lori J. Hensley, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/07/08 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George MacNabb Cremation Society of MD, Inc. Seoy EMath 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final minne Physician archae disease or condition resulting in death) /Medical Due to (or as a con quence of): Examiner ardia Secure tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examine e attending physician and d for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?

1 Yes 2 No page 2 s certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. To Be examiner Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier D06588 March 7, 2008 21042

State Registrar

DHMH 17 Rev 1/2001

9501 Old Annapolis RD, Suite 302 Ellicott City, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melvin Kordon,

31. Date filed (Month, Day, Year)

M.D.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 07853 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0337 hrs Medical Examiner March 4, 2008 Dalion A. Stanley 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/A University Hospital 9. Birthplace (State or If Linder 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Foreign Country Maryland **Funeral** Months Davs Hours Min Director 45 30 1962 1X M 2 F 216-82-6861 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show s 23a or 28a-f show Baltimore Maryland hours after death with the Maryland rector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 1701 N. Eutaw Street 21217 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 1X Yes Specify: Black If Yes, Give Year 1980-1982 1 Yes 2X No specify: 4 X Divorced Pages I and 2 should be filed within 72 hours after neut of Health and Mental Hygiens and it. If then 27 is marked other than "matural", yor other traumatic event, the Medical Examiner. 3 Widowed Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Building Demolition Fork Lift Operator 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jacqueline G. Stanley Be Robert Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2904 Erdman Avenue Baltimore, Maryland 21228 Willie B. Stanley, Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, I permit. Pages I and Department of Healt 20a, Method of Disposition rtant: If it, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03/10/08 Baltimore, Maryland tment c Metro Crematory Inc. 4 Donation 5 Other Specify: ²² Name and Address of Facility of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor (Memor 23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Stab Wound of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical tending physician a use as the burial -UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Dav 3 Ectopic pregnancy Month Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 Yes 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other₄ Residence 6 Other: ER/Outpatient 3 DOA Nursing Home 5 1 Yes ٩ 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject stabbed FOUND: 1 Natura! 1 Yes 2 ✔ No Pending the Funcral Director: npletely filled in by the Mar 4, 2008 0254 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Could not be Suicide or Town, State) 717 Druid Hill Lake Drive, Baltimore, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. March 4, 2008 K NOMI 30. Name and address of person who completed cause of death (Item 23a) 7 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD egistrar's Signatu State 2008

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07854 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death O S Day SCHMIGEL MARDELLA 9:55 A M M. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, July 26, 6. Sex 1 □ M 2 🔀 F 90 224-01-9163 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 333 Shetlands Lane 21061 **USA**

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. "natural", or items 23a or 28a-f show idical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

Director

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

3 -	333 Shetlands Lar	ne		21	.061			USA	
11	1. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	. 1.	 Race - Ame Black, White 	
	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		I □ Yes 2 XNo	Specify:	,			nite
	3 XWidowed 4 ☐ Divorced	Year or Dates:	300 de - 0					-,,-	Creation .
	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done	ation during most of wor d)	king [16b. Kin	d of Business/	Industry
11	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	3)		Ow	n Home	
17	7. Father's Name (First, Middle, Last))			18. Mother's Nan	ne (First, Middle,	Maiden S	Surname)	
	Joseph P. Cromer	-			Myrt1	e Mahane	S		
	9a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numbe	er, City or	Town, State, 2	Zip Code)
	Patricia Joh-Kal	lwa, Daughter	333 8	Shetlands	Lane Gl	en Burni	.e, M	aryland	d 21061
20	Da. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State 20b. PI	ace of Dispo emetery, cren eadown	sition (Name of natory or other place ark	ce) 03/1	Date 0/08		ation - City or idge, N	Town, State Maryland
2	1. Signature a Funeral Service Use Thomas Gregor		Ma	Name and Addre	ss of Facility Ineral Ho	me, P.A.			land 21228
2	23a. Part1. Enter the disease, or com	plications that caused the death							Approximate Interval Between
li,	shock, or heart failure. List only mmediate Cause (Final	Metallaha	8.1	minar	и С	.0.0			Onset and Death
d re	isease or condition esulting in death)	a. Due to (or as a consequ	ence of):	mman	0	MICH		-	240.
		Serre	•	02/6 07	POROS	2			3 m
Sif Ci	e uentially list conditions any, leading to immediate ause. Enter Underlying ause. (Disease or injury nat initiated events esulting in death) Last	c	ence of).	ų.		•			
	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	у		2	3d. Date of del Month	livery Day Year
Pi	art II. Other significant conditions of	contributing to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
						101	res 2	1.No 3 □ Pi	robably 4 Unknow
- -						24a. Was autop perfo		24b. Were au prior to death? 1 ☐ Yes	utopsy findings availabl completion of cause of 2 DNo
2	5. Was case referred to medical				26. Place of Dea	ath (Check only o	ne)		
	examiner? 1 ☐ Yes 2 ☐ 46	Hospital: 1 ☐ Inpatient 2 ☐ I	R/Outpatien	t 3 DOA Oth	ner: 4 Nursing H	lome 5 ☐ Resid	dence 6	☐Other (Spe	ecify)
2	7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M 28c. Injury at Work? M 1 Yes 2 No At home, farm, street, factory, office 28f. Location				now injury	occurred	
	3 Suicide 6 Could not by determined	28e. Place of injury - At hor building, etc. (Specify					Street and vn, State)	Number or R	ural Route Number,
2				e, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ind/or investigation, in my opinion, death occurred at the time, date and place, and due to the date and place, and due to the					
2	9b. Signature and little of certifier	2 MD.	se number 0 0 5 2 2	-05	29d. Date	signed (Mont	th, Day, Year)		

State Registrar SUITE 203, BALTIMORE MD-2121

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

08-01820 Harold Roy Stantor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arold Roy Stanton	1- For State	Maryland / Depart Certi	ment of H		Mental I		eg. No. 201	08 0785
Physician/	1. Decedent's Name (First, Middle,Last)					2. Date of Dea Month	th Day Year	3. Time of Death 0913 hrs
ledical Examiner	Harold Roy 4a. Facility Name (if not institution, give s	Stanton Stanton	14b.	. City, Town, or L	ocation of Dea	March 4, 2	4c. County of De	
	3939 Roland Avenue Apt. 22			Baltimore			1	V/A
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24H Hours M	lin		Birthplace (State or Foreign Country)
Director		2F	74 Yrs.	World S Days	1 logis iv	07/17	/1933	VA
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	1				10d. Inside City Limits
* .	Maryland N/	4		Bal ⁻	timore			1 X Yes 2 No
the Maryland a or 28a-f show tified at once.	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	
th the 33a or notifie	3939 Roland Avenu		140,1440		1211	Casifi Vac or No	US/	Anerican Indian, Black,
death with r items 23 nust be no	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No		, specify Cuban,		Specify Yes or No rto Rican, etc.)	White, etc	
s after de ral", or niner mu	3 X Widowed 4 Divorced If	Yes, Give Year		es 2 X No			Specify:	White
hours an natura	15. Decedent's Education (Specify only		6a. Decedent's during mos	Usual Occupations of working life.	on (Give kind on DO NOT use of	of work done retired)	16b. Kind of Busine	ss/Industry
5-0036 ed within 72 hour lygiene of ther than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Contract	or		Heat &	Air
5-0036 iled within 7 Hygiene. I other than the Medica	17. Father's Name (First, Middle, Last)			1			Maiden Surname)	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marice event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	William Bradle 19a. Informant's Name/Relationship (Typ		19b. Mailing A	Address (Street	Carr		vitt mber, City or Town, S	tate, Zip Code)
MD 21 d 2 should th and Me Ith and Me n 27 is ma umatic ev	Ruby Perkins	(sister)	763 E	Bridge D	rive, A		, MD 21122	
	20a. Method of Disposition 1 X Burial 2 Cremation 3		ace of Dispositi ematory or othe	on (Name of cemer place)	etery, Ma	arch 07	20c. Location - City	y or Town, State
Baltimore, permit. Pages 1 an Department of He- Important: If ite	4 Donation 5 Other Specify:	Moly		Cemeter		2008		e, Maryland
Balt permit Depart Impor injury	21. Signature of Funeral Servic License	le ()		me and Address			gs Funeral adena, MD	Home, P.A. 21122
Physician	23a Part I. Enter the disease, or complice failure. List only one cause on each	ations that aus dithe death. I						Approximate Interval Between Onset and
Modical xaminer	Immediate Cause (Final disease a. H	урепелsive Atheroscle		vascular Dis	ease			Death
,	h	ue to (or as a consequence of):						
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence of):						
Kaminer	(Disease or injury that initiated G	ue to (or as a consequence of).						
be executed ician and arrial - transit	d							
to, ce be execute be executed by sician and burial - tr.		AMENDED 23c. If yes, outcome of pregna	2007				23d. Date of del	iverv
ox 68760, Substitute the execution and attending physician and for use as the burial - transcript as a substitute of the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	al death 3 [Ectopic pre	gnancy	Month	Day Year
box 68760 the death certificate of the attending physiched for use as the broked for use as the broken Physician/Me	1 Yes 2 No 9 Unknown	4 Pregnant at time of deal	th 5 Oth	er (Specify)				
ords, P.O. B w requires that the d s been signed by the should be detached		contributing to death but not res	sulting in the ur	nderlying cause g	iven in Part I.			e to the cause of death?
Records, P.O. The law requires that th freate has been signed by page 2 should be detach Completed by P	Chronic alcohol abuse					1Y		Probably 4 Unknown re autopsy findings available
cords aw requast been 2 shoul						auto		r to completion of cause of
Rec The l ficate l , page				OS Plano	of Death (Che		2 No 1	Yes 2 No
Vital ysicians ysicians director	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 I	ER/Outpatient		0.0	rsing Home 5	Residence 6	Other: Scene
ion of Vital I tending Physician; eath. for: After this certif the funeral director, ation: To Be (27 Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of In	´ ´	y at Work?		e how injury occurred	
sion strendi death. ctor: y y the fi	1 ✓ Natural 5 Pending 2 Accident Investigation				res 2 No		(Stroot and Number	or Rural Route Number, City
Division of Vital Records, spital or Attending Physician: The law requiremental Director: After this certificate has been sfilled in by the funeral director, page 2 should Certification: To Be Completed	3 Suicide 6 Could not be determined	28e. Place of Injury - At hou (Specify)	me, iann, stree	t, lactory, office b	ullaling, etc.	or Town,		, ridial ridial riding on,
		n: To the best of my knowledg	e, death occurr	red at the time, da	ite and place,	and due to the ca	use(s) and manner as	stated.
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner:	On the basis of examination an and manner stated.	id/or investigati			ed at the time, dat		(Month, Day, Year)
2	29b. Signature and title of certifier	Mink	\	29c. Licens			March 5, 200	
	30. Name and address of person who co	ompleted cause of death (Item)	23a)					
y	Melissa Brassell, MD As	sistant Medical Examin	er 111 P	enn Street, E	Baltimore, N	MD 21201		
State Registra	M(1) 1 / (1)	32 aegistrar's Signati	· Ace					

OCME

Certificate of Death

	Physici	an	1. Decedent's Nam					CI	LVED	M A N	2. Date of De Month		200 ^{Year}	3. Time of Death 7:53P M
	/Medic	cal-	HOW		B				LVER	r Location of Death			County of Death	
	Examir	ier		_	e street and number) IMORE GILC	ТЭТОЦ	СТР	TOWS		r Location of Death			ALTIMORE	
58.	Funeral		5. Social Security N	lumber 6. S	Sex 7. Ag		ast birthday)	If Under	1 Year		8. Date of Bi	rth	9. Birth	place (State or Foreign
- 2	Director		218-40-	0122	M 2□F	65	Yrs.	Months	Days	Hours Min.	06/03	71942	2 000	intry) MD
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Marylan f show ied at	ò	MD	N/A		BA	LTIMO	RF						1 X Yes 2 □ No
	r 28a-	Director	10e. Street and Nu					10f. Zip	Code			10g. Citi	zen of What Cou	untry?
	th with 23a o	al D	111 HAM	LET HILL	ROAD, #12	02		,		21210				USA
	tems er mu	Funeral	11. Marital Status	V	12. Was Decedent Armed Forces?		S. 13.	Was Dece	dent of H cify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	 Race - Amer Black, White 	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	b	1		1 ☐ Yes 2 █ X If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:			ороолу.	WHITE
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212	be filed within 72 hr ntal Hygiene. ed other than "natu event, the Medical	Completed	Elementary/Seco	ondary (0-12)	College (1-4or ! 5+	5+)		PSYC					MENTAL	. HEALTH
b	a O 9	(b)	17. Father's Name	(First, Middle, Last)					18. Mother's Nam	. ,	e, Maiden	· ·	
ya	should be nd Mental marked c	은	BENJA			S	SILVER			BEATR				EAGUN
Mar	12 sh h and 7 is m traum			ame/Relationship (Type. Print) DAUGHTER		1	•	•	and Number or Ru ET CIRCL				ip Code) 33467
6,	1 and Healt tem 2		20a. Method of Dis		DAUGITER	20b. P	lace of Dispo	sition (Nar	ne of	i	Date		ocation - City or	
Б	Pages ent of nt: If it			☐Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State		emetery, cre LTIMO			03/10	0/2008	RE:	ISTERSTO	WN, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev		21. Signature of Fi			- 1	2	2. Name ar	nd Addre	ss of Facility St	OL LEVI	NSON	& BROS.	. INC.
<u> </u>	8 2 E E 8			ح ک	Mu					TERSTOWN	ROAD -	PIKE		MD 21208
			shock, or hea	art failure. List only	plications that caused one cause on each li	d the death	n. Do not en	ter the mod	le of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	W 3	Immediate Cause disease or condition resulting in death)		a	dan	romA							months
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7		Jer	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	nditions, nmediate	b. Due to (or as	a consequ	uence of):							
	nd A nd transit	Examiner	Cause (Disease or that initiated events	injury	C									
60,	sician and		resulting in death)	Last	Due to (or as	a consequ	uence of):							
Box 68760,	eath certificate battending physic for use as the b	an/Medical			d									
XO	n certifi inding use a	n/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			7					23d. Date of deli	very
	death	sicia	in the past 12 1 ☐ Yes 2	months? ☐ No	1 ☐Live birth 4 ☐ Pregnant a 9 ☐ Unknown		_	_Ectopic p ☐ Other (s _t		y 			Month	Day Year
P.O.	that the de ned by the a detached	Physici	9 Unknown		contributing to death b	ut not roo	ulting in the u	undorlying c	oues div	ron in Dort I	230 Did	tohaccou	see contribute to	the cause of death?
ds,	signer d be d	b S	Part II. Other signi	neant conditions	sonthibuting to death t	out not rest	alting in the c	inderlying c	ause giv	en in rait i.			1	obably 4 □Unknown
Division or Vital Records,	w requir been si should b	Completed									24a. Was	s an	24b. Were au	topsy findings available
Re	he lav e has age 2	dwc									auto	opsy formed/?	prior to death?	topsy findings available completion of cause of 2 No
ital	hysician: The Is his certificate ha: I director, page 2	Be Co	25. Was case refe	rred to medical						26. Place of Dea) ILITES	2 140
<u>r</u> >	hysic this ce al direc	To E	examiner? 1 ☐ Yes 2				ER/Outpatie			4 Littersing II			6 Other (Spec	oity) hospill
n o	ding Ph n. After th funeral		27. Manner of Dear	th 5 ☐ Pending investigatio	28a. Date of Inju (Month, Da	ay Year)	28b. Time o Injury	of S	28c. Injui Wor		28d. Describe	how injui	ry occurred	
isio	death ctor: ,	icati	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e 290 Place of in	jury - At ho	ome, farm, st			Yes 2 □ No	28f. Location	(Street an	nd Number or Ru	ıral Route Number,
Οį	al or A after I Dire	Certification:	4 ☐ Homicide	determined	building, e	tc. (Specif)	y) '				City or To	òwn, State	e)	
(2)	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)	1 ← Certifying P 2	hysician: To the best miner: On the basis of and manner st	of examina	wledge, dea tion and/or in	th occurred	at the ti	me, date and place opinion, death occu	e, and due to the	e cause(s e, date an) and manner as d place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and	title of certifier				29	c. Licens	e number		29d. Da	te signed (Monti	h, Day, Year)
			▶ (1)	und	~m				1	58303		Ma	rch 7	4008
	15		30. Name and add	ress of person who	completed cause of o	death (Item	23a) (Type)	Print)	Lary	les S+	Towson	w	rch 7	+
, 302	Sta Regist	_	31. Date filed (Mor	oth, Day, Year)		rar's Signa	turo	· Ch				-		

		,	For State Registrar	State of	Marylan		tificate			ıvıer	пат ну	giene Reg. No	200	8	07857
¥	Physici		1. Decedent's Name (First, Middle ANNA A. STEINE	, ,							Date of De Month ARCH	Da	y Yea 200		3. Time of Death 4:45 A ^M
	/Medio		4a. Facility Name (If not institution		ber)		4b. City,	Town, or l	ocation of De				c. County of De		
			GENESIS PERRIN					RKVII					BAL'		
	Funeral Director		5. Social Security Number 213-01-4823	6. Sex 1 □ M 2 💢 F	'. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi	in. J	Date of Bir (Month, Da AN 27	th ay, Year •190	9. 8	Birthpla Countr	ce (State or Foreign y) MD
	ryland how at		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	d. Inside City Limits
	e Ma 3a-f s	cto	MD N/A		BA	LTIMOR	E								1 XYes 2 No
	or 20	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	itizen of What	Countr	y?
	s 23a	eral	2824 INGLEWOOD	AVE 12. Was Deced	lont Ever in II	S 12 1		1234	pania Origin?	(Cnoolf)	Von or Ne		USA 14. Race - Ar	narical	n Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Itiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mari 3 ☐ Widowed 4 ☐ Divorced	ried Armed Ford	ces? 2∐4No	1	f Yes, spec 1 ☐ Yes 2		panic Origin? , Mexican, Pu Specify:	erto Ric	an, etc.)	0-	Black, W		c.
2-00	172 hou "natura edical E	leted	15. Deceden (Specify only highe	it's Education est grade completed)		16a. Dece	dent's Usua kind of wor	al Occupat	tion uring most of v	vorking		16b. k	Kind of Busines	ss/Indu	stry
Maryland 21215-0036	ed withir ygiene. Ier than t, the Me	Completed	Elementary/Secondary (0-12) 6th	College (1-	4or 5+)	1	EMAKE	R					N HOME		
land	uld be file fental H rked oth tic even	To Be	17. Father's Name (First, Middle, JOSEPH KLIMA	Last)					18. Mother's N ANT		irst, Middle A SMR		n Surname)		
ary	she man		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street ar	nd Number or	Rural R	oute Numb	Number, City or Town, State,			Code)
	and 2 ealth m 27 l	c 9	NORBERT KLIMA-	BROTHER					OOD AVE				E, MD 2		
Baltimore,	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from S	tate C	Place of Dispo cemetery, crei METRO	sition (Nan natory or o	ne of ther place)	Date	UNIL		ocation - City		
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service	Licence		I .	2. Name an						FUNER 21206	AL	HOME, INC
-			23a. Part1. Enter the disease, or shock, or heart failure. Linimmediate Cause (Final												Approximate Interval Between Onset and Death AYS
	Physician /Medical		disease or condition resulting in death)	a. SEPS	IS or as a conseq	uence of):		-						+	
K	Examiner	_	Sequentially list conditions,	b	MONIA r as a conseq	uanca of):								W	EEK
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		LASIA	derice or).								Y	EARS
20,	ificate be executed g physician and as the burial-transit	I Exa	resulting in death) Last	C	r as a conseq	uence of):									
68760	icate t physic	edical		d											
P.O. Box (ath cert attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown		th 2 ☐ Feta nt at time of d	death 3□	Ectopic pr Other <i>(sp</i>						23d. Date of o		y Day Year
σ.	w requires that the d been signed by the should be detached		Part II. Other significant condition	ons contributing to dea	ath but not res	ulting in the u	nderlying ca	ause giver	n in Part I.		23e. Did	tobacco	use contribute	to the	cause of death?
rds	quires n sign ald be	d by	DEMENTIA							_	1 🗆	Yes 2	2 □ No 3 □	Proba	bly 4 Unknown
Vital Records,	ne law rec has bee ge 2 shou	Completed	ASCVD								24a. Was		24b. Were	autop	sy findings available pletion of cause of
ř		Com									pert 1∐ Yes	ormed?	death	?	No
/Ita	clan; sertific setor,	Be	25. Was case referred to medica examiner?						26. Place of D						
	<u>0</u> + 0	₽.	1 Yes 2√ No 27. Manner of Death	Hospital: 1 □ In 28a. Date of	patient 2 Injury	ER/Outpatier 28b. Time o			4 LA Nursing				6 □Other (S	pecify)	
on	hding th. : After : funel	tion	1 Natural 5 Pendir 2 Accident investi	ng (Month	, Day Year)	Injury	M	8c. Injury Work? 1 □ Y	es 2∐No	200	. Describe	now mje	ary occurred		
Division or	i or Attending after death. Director: After d in by the funer	Certification:	3 Suicide 6 Could determ	nined 20e. Place (of injury - At ho g, etc. <i>(Specif</i>		eet, factory	, office		28f.	Location ((Street a	and Number or te)	Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	ng Physician: To the base and manner	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the time , in my op	e, date and pla inion, death o	ace, and	I due to the at the time	e cause(:	s) and manner nd place, and o	as sta	ited. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifie	r			290	. License	number			29d. Da	ate signed (Mo	onth, D	ay, Year)
)	<		Wend >	cut me	>			P3	31295	-		7	15-10	~	
6	Y	İ	30. Name and address of person					ישר אים	02 T	Otico	N, MI				
)	40	Wandy Moes- 31. Date filed (Month, Day, Year)		gistrar's Signa			.E 42	UZ I	OWDU	TII en	. 41.	<u></u>		
	Sta	te	MAD 1 1	2008	Orgalic	k A	made a								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year TATE JR. **Physician** 3 AWRENCE FEB 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner 400 SAMALIAN HOSPITAL BALTIMO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 217-92-5082 36 Director Nov. 16, 1971 M Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 Yes 2 No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be USA I. Race - American Indian, Black, White, etc. 10 Bykes Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specif African-American 1 □ Yes 2 No Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paragon Security Company Security Guard permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens important: If then 27 is marked other the any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence O. Tate Sr. Lucender Leggett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 240 Highmeadow Road, Reisterstown, MD 21136 Lucender Leggett/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2-18-08 King Memorial Park Woodlawn, MD 21. Signarie of Fune/al Service Licensee 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTI OKCIAN **Physician** disease or condition resulting in death) /Medical TO PNEUMONIA+ BACTERIMIA Examiner SELONDARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mune DEFICIONCY SANDUNG certificate be executed attending physician and for use as the burial-tran Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VANCYTORENIA 2 No 3 Probably 4 Unknown Completed KAPOSI SARCOMA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 D No certificate 1□ Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 2 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of partifier RES DOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMPRETAN HOSDAL RMG 500 TARAT ROSEMARIE

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State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	,		nt of Heal			giene Rog. No.	008	0 /859	3
			Decedent's Name (First, Middle, La	ast)					2. Date of De	ath		3. Time of Death	
	Physici		LUTHER	JAMES '	THOMPSON				Month MARCH	Day	2008	1:10 0.	A
	/Medio Examin		4a. Fecility Name (If not institution, gi			4b. City	Town, or Loca	ation of Death		4c. (County of Death		_
	LAGITIII		9605 Woodberry	C+		Sea	brook			Р	G		
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday		r 1 Year If t	Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da	h	9. Birth	place (State or Foreig	חק
	Director		259-42-0398	1 X M 2 F 7	8 Yrs.	MONUIS	Days Ho	Julis Iviiri.	9-23-		_	rgia	
	P _		Usuet Residence of Decedent		10c. City, Town or L							10d. Inside City Limit:	
	arylar show	_	10a. State 10b. County		•							You Yes 2 N	
	8a-1	Director	MD PG		Seabrook					40. 000	en of What Cou		_
	Vith th	Pre	10e. Street and Number				p Code				en of what cou	intry r	
	death with the Maryland ms 23a or 28a-f ehow r.must be notified at	rai	9605 Woodberr				706	oin Origin 2 /Sp	ecify Yes or No	USA	4. Race - Ameri	ican Indian	
	er de litem	Funeral	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent E Armed Forces? 1 X Yes 2 □ No		If Yes, spe	ecify Cuban, M	exican, Puerto	Rican, etc.)		Black, White		
5	l', or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: K		1 🗌 Yes	21XNo Sp	oecify:			Specify:Bla	ck	
3-003p	within 72 hours after ene. then "neture!, or ite	ed	15. Decedent's 8		16a. Dec		al Occupation				nd of Business/Ir		
3	n n	Completed	(Specify only highest gi	rade completed) College (1-4or 5+	iite.	e kind of w DO NOT i	ork done during use retired)	g most of work	ring	Dwi	vate		
7	d with	E	12th	College (1 407 57	Past	or				PII	vale		
<u> </u>	be filed within 72 hours after death with the Marylar lat hygiene. d other then "neturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Las	t)			18.	Mother's Nam	e (First, Middle,	, Maiden .	Sumame)		
land	Aental Aental rked c	ToE	Roger Thompso	n Sr.			FM	nnie	Lee Wh	ite			
Mary	should end Men le marke sumatic	,	19a. Informant's Name/Relationship		19b. Mai	ling Addres	s (Street and I	Number or Rui	al Route Numb	er. City or	Town, State, Zi	ip Code)	
_	ss 1 and 2 should lof Heelth end Meni		Daisy Lee Thon	pson/Wife	9605 20b. Place of Disp	. Woo	dberry	/ St	Seabro	ok,	MD 207	06	
ze,	ges 1 and of the Herror or oth		20a. Method of Disposition	□Domoual from State	20b. Place of Disp cemetery, cri	oosition (Na ematory or	other place)						
Ĕ	Pages nent of int: If It iry or o		1 Burial 2 □ Cremation 3 Donation 5 □ Other (Spec		Ft. Lin	coln	Ceme	. 3-7-			itwood,		
Baitimor	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Uca	TISSES LOS	1	22. Name a	nd Address of • Nort	Facility Ro h Ave	nalgTa	ylor	e,MD	neral HM	√ .
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do not e	nter the mo	de of dying, su	ich as cardiac	or respiratory a	rrest.		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		C ARRHYTH	мта						Onset and Death	
	/Medical		resulting in death)	- u	consequence of):	ША							
	Examiner		On any state of the same distance	h ATHERO	SCLEROTIC	CORO	NARY AF	RTERY D	ISEASE				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
/	cuted nd ransi	Examin	that initiated events	0.	ES MELLIT	US							
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8/60,	ate be	dical	•	d									
٥	ng pt	Wed	IF FEMALE:										
X R R	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1⊟Live birth	2 ☐ Fetal death 3	Ectopic				2	23d. Date of deli Month	very Day Year	
	0 0 0	Sici	1 ☐ Yes 2 ☐ No	4⊡Pregnant at t 9⊡ Unknown	time of death 5	Other (specify)						
J.	requires thet the een signed by th hould be detache	F	9 Unknown					Dodl	23e Did	tobacco u	sa contributa to	the cause of death?	
	es theligned be det	à	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying	cause given in	i Pan i.		Yes 2		37	WΠ
5	A requir	ted											
ပ္ပ		p de							24a. Was auto	nsv	prior to d	topsy findings availab completion of cause o	
r	The ate has page	Completed							1 ☐ Yes	ormed?	death?	2 X) No	
Vital Records,	Physicien: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	A second			04		th Check only	-			
	Physia this c	ို	1 ☐ Yes 2 No	Hospital: 1 Inpatier				4 Nursing H			6 ☐Other (Spec	cify)	
_	ding P h. After t funera	<u></u>	27. Manner of Death 1 Maturat 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	,	28c. Injury at Work?	. C.N.	28d. Describe	now intur	y occurred		
<u> </u>	Attending in deeth.	cati	2 Accident investigati 3 Suicide 6 Could not	he -		М		2 🗆 No	OR Location	(Stroot on	d Number or Pi	ıral Route Number,	
Division of	F & F C	Certification;	4 Homicide determine		ury - At home, farm, : c. (Specify)	street, tacto	огу, опісе		City or To	wn, State)	iai Aobie Number,	
	To the Hospital of within 24 hours of To the Funeral completely filled in		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge de	ath cocur	d at the time	tate and place	and due to the	Causo(s)	and manner as	stated	
	Hos 14 ho Fun fely f	lica	(Check only 2 Medical Ex-	aminer: On the basis of and mannerista	examination and/or	investigation	on, in my opinio	on, death occu	rred at the time.	, date and	place, and due	to the cause(s)	
	To the Hospital within 24 hours e To the Funerel I completely filled	Medical	29b. Signature and Ittle of certifier	2/1		2	9c. License nu	mber		29d. Dat	te signed (Monti	h. Day, Year)	
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	7		30. Name and address of person who PETER F. STENGEL				TREET N	W, WAS	HINGTON	, DC	20422		
	Sta	ato.	31. Date filed (Month, Day, Year)		ar's Signature			-					-
	Regist		848D 1 1 20		K L	all!							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MONNAY 7:00 AM MONI 0 2008 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL Examiner HOWARD COUNTY COLUMBIA HOWARD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 X F Hours 76 Yrs. 1932 234-52-2528 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 **USA** 3400 Oak West Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Bever Tracy C. Kittle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3400 Oak West Drive Ellicott City, MD 21043 James D Vannoy, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/07/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2. Name and Address of Facility Cremation Society Of Maryland, Inc. 21. Signature of Funeral Service Licensee
Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEAD & NECK CANCER METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEOMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine RENAL FAILURE EMENTIA Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: 1 Hinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, been signed by certificate has this After 1 hin 24 hours after death the Funeral Director: filled in by the

Baltimore, Maryland 21215-0036

State

Registrar

within To the

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31. Date filed (Month, Day, Year) MAR 11

29b. Signature and title of certifier

Seilattra

2008

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE, COLUMBIA - MD edistrar's Signature

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0064539

29d. Date signed (Month, Day, Year)

03/06/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nomas Walker		State of Maryland / Department of Health a For State Certificate of Death	and Mental Hy		2 (008 0786
° Physician ledical Examine	/ 1	1. Decedent's Name (First, Middle,Last) Thomas Walker Jr	-	2. Date of Death Month March 5, 2	Day Year	3. Time of Death 1421 hrs
,		4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, Baltimore	, or Location of Death		4c. County of D	eath
Funeral	Ę	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		8. Date of Birtl	(MM/DD/YYYY) 9	Birthplace (State or Foreign Country)
Director		212-78-0370 1XM 2 F 48 Yrs. Months C	Days Hours Min.	1-12-	-1960	MD
	_	Usual Residence of Decedent				10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location				1 Yes 2 No
Aaryland 28a-f show 1 at once.	<u>.</u>	MD N/A Baltimore 10e. Street and Number 10f. Zip Cod	le	10	g. Citizen of What	Λ
th the Maryland 23a or 28a-f sho notified at once	DIrector		21234		USA	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shound the Maryland has been seened, the Medical Examiner unst be notified at once the file of the Medical Examiner with the notified at once the file of the Medical Examiner of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the file of the fil		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	Hispanic Origin? (Sp			American Indian, Black,
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after ral", c	声 -	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes XX		work done	Specify: 16b. Kind of Busin	
"natu	<u>g</u> -	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occuduring most of working			Too. Tand of Edoir	N/A
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than re event, the Medics	וכ	17. Father's Name (First, Middle, Last)	18.Mother's Name			
d be filemal larked	o Be	Thomas Walker, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S	Dorothy Street and Number of	Faye I	Morton	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumantic event, the Addical Examiner	١,	Marian Morton - Sister 620 N. His				
e, N and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of	f cemetery,	Date	20c. Location - C	ity or Town, State
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Baltimore, permit. Pages I ar Department of Het Important: If ite injury or other tr	ŀ	21. Signature of Fundral Service Licensee 22. Name and Add	ress of Facility Ma	arch F,	H East	
E P P E		Synetle K. mes 1101	E. North	n Aveni	ie Balto	MD 21202
Physician dical		23a. Part I. Effer the disease, or complications that caused the death. Do not enter the mode of dy failure. List only one cause on each line.				Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardionepaly with Left Ven Due to (or as a consequence of):	tricular I	hypertro	phy and dilatio	
	1	Sequentially list conditions, b			unati	M
	<u></u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.				
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	dical	d.	077.0.4			
e be ex		XUNPENDED X AMENDED 1,23a,pt.II,27 per un	ne g877 3-2	24-08 vt	23d. Date of d	elivery
68760 certificate t nding physise as the bu	<u>ڇ</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregn	ancy	Month	Day Year
Box 68760 death certificate I the attending physed for use as the b	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown				
that the death need by the att detached for	좕	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
P.O.	[호	End Stage Renal Disease		1 Ye	s 2 No 3	Probably 4 Unknown
ords, w require ss been si	ete			24a. Was auto	osy pri	ere autopsy findings available for to completion of cause of
Reco The law icate has	Completed by			perfo 1 ✓ Yes		eath? ✔ Yes 2 No
of Vital Records, ng Physician: The law require ther this certificate has been si morral director, page 2 should	ğ Be	20, 17ds date foreited to interior	Place of Death (Check			
Vit	ၟႍႃ	1 Yes 2 No Inpatient 2 FR/Outpatient 3 DOA	Other; Nursi	ng Home 5	Residence 6 how injury occurre	Other:
n of V		(Month, Day, Year)	Yes 2 No	200. Describe	now injury occurre	
Division tal or Attendi rs after death. al Director: A	ig	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, of				r or Rural Route Number, City
Divisior spital or Attené hours after death meral Director; y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town,	State)	
	Medical C	29a. Certifier (Check only ona) Certifying Physician: To the best of my knowledge, death occurred at the time ona) Medical Examiner: On the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation, in my open of the basis of examination and/or investigation and other or in	ne, date and place, an binion, death occurred	d due to the cau at the time, date	se(s) and manner a and place, and du	as stated. le to the cause(s)
To the within To the comple	ĕ Z	and manner stated.	icense number			d (Month, Day, Year)
		anesa	D.C.M.E.		March 6, 20	08
_	ł	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Bal	Itimore MD 2120)1		
Cto	10	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Bal 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MITOIO, NID 2120			
Sta Registr	_	MAD 1 1 2008				
DHMH 17 Rev 1/200	01	ORIGINAL				

State Registrar 31. Date filed (Month, Da

of person who completed cause of death (Item 23a) (Type Print)

Registrar's Signature

		Please	Type or Print in E					
		For	State of Marylan	•		Mental Hy	giene 2 n n s	8 07863
		1 - State Registrar		Certificat	e of Death		Reg. No.	3 01000
Physicia	an	Decedent's Name (First, Middle, Last	at)			2. Date of De Month	Day Year	
/Medic		Kichard 1	111	oolery		03	10 200	
Examin	- 3	4a. Facility Name (If not institution, give		P	Town, or Location of Deat	th	4c. County of Dea	
	- FF	FRANKLIN Socare 5. Social Security Number 6. S	HOSPITAL CEN		1 Year If Under 24 Hrs	8. Date of Bir	th 9. Bi	irthplace (State or Foreign
Funeral Director			MM 2□F 1.8	Yrs. Months	Days Hours Min.	. (Month, Da	ly, Year)	Country)
		Usual Residence of Decedent	1 0/8				7 7 7 0 11.10	
rylan how	_	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
e Ma 3a-f s tiffied	cto	MD Balti	more	Balt	more			1 ☐ Yes 2 ☑ No
ith th or 28	Director	10e. Street and Number	0	10f. Zip			10g. Citizen of What C	Country?
ath w s 23a nust b		110 Hapsburg	Court		21234	2	USF	nerican Indian,
er de items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ▼Yes 2 □ No	If Yes, spe	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	rto Rican, etc.)	Black, Wh	
rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2☑No Specify:		Specify:	hite
2 hou atura cal E	pa	15. Decedent's Ed	lucation	16a. Decedent's Usu	al Occupation	.,	16b. Kind of Busines	s/Industry
nin 72 In "na Media	ple	(Specify only highest gra	College (1-4or 5+)	(Give kind of wo life. DO NOT u	rk done during most of wo se retired)	orking	-	
d with	Completed	12		Wareh	ouseman		132, Mr	<u>rolesale</u>
al Hy I othe	Be (17. Father's Name (First, Middle, Last,			18. Mother's Na	me (First, Middle	, Maiden Surname)	
Ment Ment arkec	Tol	Howard	Woolery			rie L	ohite_	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (19b. Mailing Address	(Street and Number or F	O .		1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Charlene Wool	1 20h F	Place of Disposition (Nat	ne of a Court	Date	20c. Location - City	
Pages 1 nent of h unt: If ite ury or ot		1 ☐ Burial 2 ☑ Cremation 3 ☐	Bemoval from State	cemetery, crematory or	ther place)			,
it. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (Specifical Service Lice)	n) Cre.	nation Service	es-locair o	11-2008	torest HI	1, Maryland
permi Depa Impo any it		21. Signature of Furieral Service Licer	man t	Evans	uneral Chap	of + Cremo	ation Service	es-Parkuille
	_	23a, Part1, Enter the disease, or com	plications that caused the deat		larford Koas le of dying, such as cardia		uille mb	Approximate
Dhamisis	8 5	shock, or heart failure. List only	one cause on each line.	Eli	i i			Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	a. Due to (or as a conse	uence of):	15			
Examiner				,				
ST WIE	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				
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be executed cian and ourial-transit		resulting in death) Last	Due to (or as a conseq	uence of):				
w requires that the death certificate be even the signed by the attending physician should be detached for use as the buriar	Physician/Medical		d					-
ertific ding p	/Me	IF FEMALE:	23c. If yes, outcome pf pregna	ancv			22d Date of a	foliven
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 Ectopic p			23d. Date of o	Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	JEJOINEI (4				
that the the the the the the the the the th		Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	ause given in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
juires n sign	d by	Chronic Kidne	y Disease	Hortis	Stenosis	. 1 🗆	Yes 2 No 3□	Probably 4 ☐Unknown
w rec	Completed	Renal transpla	ant Brain	lesions		24a. Wa	s an 24b. Were	autopsy findings available to completion of cause of
he lav e has	ршс	5:116	1 12 1-111	1-0.011		eauto perl 1 Yes	ormed2 death	to completion of cause of ? es 2□ No
an: tifica tor, p	Be C	1) ia he tc> 25. Was case referred to medical			26. Place of De	eath (Check only		
nysici iis cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 De	OA Other: 4 Nursing	Home 5 ☐ Res	sidence 6 Other (S	pecify)
ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
endir sath. or: Ai	atic	2 ☐ Accident investigation		M	1 ☐ Yes 2 ☐ No			
or Att ter de virect n by t	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factor fy)	y, office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
urs all		29a, Certifier 1 Certifying Pi	nysician: To the best of my kno	wledge doath occurred	Lat the time, date and pla	ce, and due to the	e cause(s) and manner	as stated
To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. Within 24 hours after death. Within Euneral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only 2 Medical Exal	niner: On the basis of examination and manner stated.	ation and/or investigatio	n, in my opinion, death oc	curred at the time	e, date and place, and	due to the cause(s)
o the	Me	29b. Signature and title of certifier	1	29	c. License number		29d. Date signed (Mo	onth, Day, Year)
C > F 0		1/2/	L 11 1		0006521	12	3/10	108
14		30. Name and address of person who	completed cause of death (Iter		- -	. •	1.0/	<u> </u>
47		DR TAMARS. SMITH			are DR	Balti	more n	nd 21237
Sta		31. Date filed (Month, Day, Year)	32. Raistrar's Sign		3			
Registi	ar	4 1	2000	AST ASTALLAND	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		Otato c		,	Cer	tificate of	Death	nontai 11	Reg. No.	2008	071	864
85	Physicia	an	1. Decedent's Name (First,						-		2. Date of De Month	eath Day	Year	3. Time of	
	/Medic		WILLIAM F.								MARCH	8,	2008	7:25	P. ^M
	Examin	er	4a. Facility Name (If not inst			mber)				r Location of Death		4c.	County of Death		
100000	-	204	STELLA MAR 3 5. Social Security Number	S HO		7 Age /	In yrs. last b	nirthday)	TIMONI If Under 1 Year		8. Date of Bi	rth	BALTIMO	RE place (State o	r Foreign
	Funeral Director		218-12-0625 Usual Residence of Decede		№ 2 □ F	8	•	Yrs.	Months Days	Hours Min.	2/12/1	ay, Year)	Cou	LAND	- Toroign
/land	at		10a. State 10b. Co			1	0c. City, To	wn or Loc	ation					10d. Inside Ci	ty Limits
Man	a-f sh ified	tor	MD ST	. MA	RYS		CHARL	COTTE	HALL					1 ☐ Yes	2 X No
th the	or 28a e not	Director	10e. Street and Number						10f. Zip Code			10g. Citi	zen of What Cou	intry?	
ath wi	23a ust b		29449 CHARLO	TTE	HALL RD	• A	PT. C-		20622-3				USA		
er dea	tems ner m	Funeral	11. Marital Status		12. Was Dec Armed F	orcas?		13. W	as Decedent of F Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	 Race - Amer Black, White 		
2 should be filed within 72 hours after death with the Maryland	It of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ 3 □ Widowed 4 ☒ Div		If Yes, G Year or I	2 □ No ive Dates: W	WII	1	∐Yes 2∭XNo	Specify:			Specify: WH	ITE	
72 h	"natu edical	Completed	15. Dec (Specify only	edent's E highest gr	ducation ade completed,		16	(Give k	ent's Usual Occup aind of work done O NOT use retired	during most of work	king	16b. Ki	nd of Business/h	ndustry	
withir	than the Me	dmo	Elementary/Secondary (0		College (1-4or 5+)			I ENGINEE	•		MAI	VUFACTUR	TNIC	
filed	Hygin Sther		17. Father's Name (First, M			<u>'</u>	, DL	<u> </u>	_EIVGIIVEE	18. Mother's Nam	e (First, Middle			IIVG	
ld be	ked c	To Be	WILLIAM WIE	SSNE	R					ANNA M	. BECK				
shou	and M s mar iumat		19a. Informant's Name/Rel	ationship	(Type. Print)		19	9b. Mailing	Address (Street	and Number or Rui	ral Route Numi	ber, City o	r Town, State, Z	p Code)	
and 2	Health are 27 is the tra		SANDRA A. M	RRAY	/DAUGHI	ER			LUBSIDE		EYTOWN,		21787		
S 4	r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema	ıtion 3 [· ∃Removal from	State	20b. Place cemen	of Dispos tery, crem	sition (Name of patory or other plac	ce)	Date		cation - City or 1	own, State	
. Pages	tant: jury c		4☐Donation 5☐Ot	ner (<i>Speci</i>	ify)		LAKE		MEM. PAF		2/2008	SYKI	ESVILLE,	MD	
permit	Department of Important: If any Injury or once.		21. Signature of Funeral Se	rvice rice	olar	جب			Name and Addre	rss of Facility THI RAVEN BL			UNERAL H	OME, P 286	.A.
150	4 A		23a. Part1. Enter the disea shock, or heart failure	s, or con	nplications that	caused th	e death. Do							Approximat Interval Bet	ween
Phy	ysician		Immediate Cause (Final disease or condition		a SEP									Onset and I	Death
	Medical		resulting in death)	-			consequenc	e of):							
EX	aminer	L	Sequentially list conditions,		b			0:							
pe	ısit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events	₹	Due to	(or as a	consequence	e or):							
y execu	al-trar	Examiner	that initiated events resulting in death) Last		cDue to	(or as a c	consequence	e of):							
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tificat	ig physician and as the burial-transit	Medical													
at cer	attendir for use		IF FEMALE: 23b. Was decedent pregna		23c. If yes, ou 1□Live		pregnancy □Fetal dea	ath 3□	Ectopic pregnanc	у			23d. Date of deli		Voor
LIVISION OF VITAL INCOMES, F.O. BOX 00/00,	signed by the at be detached fo	Physician/I	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9∐Unki		ne of death	5 🗆	Other (specify)				Month	Day	Year
that	ed by detail		Part II. Other significant co	nditions	contributing to	death but	not resulting	in the un	derlying cause giv	en in Part I.	23e. Did	tobacço ı	ise contribute to	the cause of c	leath?
requires	n sigr uld be	d by									1 🗆	Yes 2	□ No 3□ Pro	bably 4X	Jnknown
N N	s been si	Completed									24a. Wa		24b. Were au	topsy findings	available
The	te ha	mo									auto perl 1□ Yes	opsy formed? 2 X No	death?	ompletion of c 2□ No	ause of
an:	s certificate has b irector, page 2 s	Be C	25. Was case referred to m examiner?	edical						26. Place of Dea					
Physic	his ce I direc	ToE	1 ☐ Yes 2 X No				2 ER/0			4 LI Nursing H			6 NOther (Spec	ify) HOS	PICE_
ing P	n. Arter this certificate ha funeral director, page			ending		of Injury onth, Day	(ear) 28b	o. Time of Injury	28c. Inju Wor		28d. Describe	how injur	y occurred		
ttend	er death. rector: / by the f	icati	3 Suicide 6 □ C	vestigation	oe 290 Blac	a of injury	. At home	farm etre	M 1 □	Yes 2 □No	28f. Location	(Stroot an	d Number or Ru	ral Pauto Nun	phar
A P	Direct Direct In by	Certification:	4 ☐ Homicide	etermined		ding, etc.		iaiii, sire	et, factory, office			own, State		rai noute Nuii	iber,
spital	neral rilled									me, date and place					
ne Ho	within 24 hours are To the Funeral Discompletely filled in	Medical	(Check only 2 Me	dical Exa		basis of e nner state		and/or inv	estigation, in my	opinion, death occu	rred at the time	e, date and	d place, and due	to the cause(s	s)
To th	To ti	ž	29b. Signature and title of o	erthier					29c. Licens				te signed (Month		
	, 1			1	2				DA.	3725		-	31101	08	
1	HI		30. Name and address of p			se of dea	th (Item 23a	a) (Type, F							
١	\		DR. TARIO M 31. Date filed (Month, Day,	Year)	32.		ANEY s Signature		EY RD.	TIMONIUM,	MD 210	093_			
	Sta Registr	-	MAR 1	1 200	18	Jan .	Ju f	5330							

Registrar
DHMH 17 Rev 1/2001

State

3001, S. Hanover St. Baltimore MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

Khandelwal MD

MAR 1 1 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joan Day **Physician** Marlene Wheat Month 2008 11:30a March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Canton Harbor Baltimore, MD 8. Date of Birth (Month, Day, Year, 9/26/1941 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Social Security Number 220–38–5203 **Funeral** 9. Birthplace (State or Foreign Months Hours Min 1 □ M 2 □ XF Days 66 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notifled at 28a-f show MD Baltimore 1 XYes 2 No Director 10f. Zip Code 21230 10e. Street and Number 10g. Citizen of What Country? 1433 Decatur Street USA item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must to Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 If Yes, Give 2 No 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify. þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bindery Worker Printing 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be file nt of Health and Mental H: I: If item 27 Is marked oth Be George Irvin Fornoff Sr. Margaret Elizabeth Fogarty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Barlow / Niece 1808 Jackson Street, Baltimore, MD 21230 **Baltimore**, 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State injury or permit. Page Department o Important: If 3/10/2008 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funral Home INc. 21. Signature of Euneral Service Licensee Victor P. Doda any. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, a simplication. That caused shock, or heart failure. List only one cause on each line That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AILURE DNGESTIVE /Medical Due to (or as a consequence of) Examiner FNOSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed Due to (or as a consequence of) burial Box 68760. physician Physician/Medical the as attending IF FEMALE: use . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9□Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ð DISETSE 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? Yes 2.2.No page Vital 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No ပ 1 Inpatient 2 ER/Outpatient 3□ DOA Division or After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

2008 MAR 1 1 Registrar

29b. Signature and title of certifier

ASNEEM 31. Date filed (Month, Day, Year)



and manner stated

e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

AVE

SUITE 203,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Martha B. Whittenberg Month ^{Day} 2008 **Physician** March 7, 10:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Sunrise Assisted Living Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2√2 Months 02/26/1915 120-07-0192 93 AT, Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Montgomery Rockville 1 Taryes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 USA 8 Baltimore Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ◯XNo Specify Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Butler Unknown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Chateau Way, Birmingham, AL 35242 19a. Informant's Name/Relationship (Type. Print)
Larry Sartore / Son in-law 20b. Place of Disposition (Name of cemetery, crematory or other place Elmwood Cemetery) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/12/2008 Birmingham, AL 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Charles L. Stevens Funerla Home Inc. 1501 East Fort Avenue, Baltimore, MD Loveto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) 3 months **Physician** Cerebra1 Hemorrhage /Medical Due to (or as a consequence of): **Examiner** 3 Years Advanced Dementia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760. attending physiclan for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Stage II Sacral Decubitus Ulcer 1 Yes 2 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1 Yes 2 No Division or Vital Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU8 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Randallstown Baltimore 8. Date of Birth Month, Pay, Year, May 11, 1911 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Davs Months Hours 1 □ M 2 🖫 F 213-48-5481 96 SC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annex. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Paltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3605 Hillsdale Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Walker Minnie Walker ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freida A. Jones/Guardian of person 10 N. Calvert St., Suite 300, Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 3-13-08 Arbutus, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses TanaOn 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that in its tool as the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ②No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 TYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 No 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D To the Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 037573 8005 P 30. Name and address of person who comple e of death (Item 23a) (Type, Print) ZLACH Main MD 25 Sty. 21136

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31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** narch 2008 M_{\bullet} Wright Anne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimone ose Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 9, 7. Áge (In yrd. last birthday 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1□M 2XF 1937 Maryland 213-34-5528 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Parkville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 3051 Arizona Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items: any injury or other traumatic event, <u>the Medical Examiner m</u>u Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Mars Supermarket 12 Bakery Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Graham J. Cusic, Sr. Marie Anne Tini Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3051 Arizona Ave. Parkville, MD 21234 Francis E. Wright/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c Location - City or Town, State March 11, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 2008 Rosedale, MD 4 □ Donation 5 K Other (SpecifyEntombment Cemetery Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Inc. Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, it any, accepts the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>۾</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2□No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗖 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

the Hospital or Attending Physician: n 24 hours after death.

Ie Funeral Director: Af
bletely filled in by the fur To the Hos within 24 ho To the Fun completely i

> State Registrar

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32. Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated

who completed cause of death (Item 23a) (Type, Print)

Square Drive Baltimore, Md 2/237

29c. License number

3/4/08

29d. Date signed (Month, Day, Year)

29b. Signature and title

Name and address of b

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:19 P M March 5, 2008 Wier Charles Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium Baltimore Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F Director 84 Nov 20, 1923 Maryland 218-26-8976 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County f show r 28a-f show notified at 1 ☐ Yes 2 No Director Baltimore Timonium Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ? must be r USA Funeral 2525 Pot Spring Road, #203S 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Lumber n/a Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be artment of Health and Mental I ortant; If item 27 Is marked or Injury or other traumatic eve Griffith Wier, Sr. Helen 2 John Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road, #203S, Timonium, MD 21093 Shirley Anne Wier/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3/7/08 Catonsville, Maryland Metro Crematory permit. De artm Imr orta any inju once. 21 Signature Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD Inter the disease, or complication, that cause the or heart vilure. List only one cause on each, ne Approximate Interval Between Onset and Death 23a, Part1. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Cause (Fir al disease o condition resulting i death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, if see or in the property of that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? /es 2 No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE P 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 316108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Medica	ו	1. Decedent's Name (Fifst, Middle	Charles	Thor	mas V	Valpole,	Sr.	Month March	Day	2008 Year	3. Time of Deat
amine	-	4a. Facility Name (If not institution	n, give street and number)			4b. City, Town,	or Location of Death		4c.	County of Deat	h
		Stella Maris				Timon				Baltimo	
eral ctor		5. Social Security Number 212–32–9655	1⊠M 2□F	je (<i>In yrs. la</i> 70	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan • 1	iv. Year)	Co	hplace (State or For untry) 'yland
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otified	Director	Maryland Bal	ltimore			106 7in Code	Dundalk		40. 0%	i	1 □ Yes 2 □
be .						10f. Zip Code				izen of What Co Lted Sta	-
nust	E E	8340 Bletzer	Road 12. Was Decedent	Ever in LLS	13	Was Decedent of J	Hispanic Origin? /Sr	polify Von or No		14. Race - Amer	
miner r	/ Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Forces? ried 1 ☐ Yes 2 ☑ If Yes, Give			If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.))-	Black, White	e, etc.
Exa	o o	3 Midowed 4 Divorced	Year or Dates:								White
ledica	Completed	(Specify only highe	t's Education st grade completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of worked)	king	16b. Ki	ind of Business/	Industry
the		Elementary/Secondary (0-12) 12 Years	College (1-4or !	5+)	Merch	andise D	irector		Fo	od Indu	stry
vent,	9 -	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle	, Maiden	Surname)	
atle e		John L. Wal	.pole				Mae D.	Conway			
anma		19a. Informant's Name/Relations	hip (Type. Print)		ľ	-	t and Number or Ru		-		
Per t	-	Maria Y. Trace	y (Daughter)	last St		25 Tall C				Maryland	
ry or ot		20a. Method of Disposition 1X Burial 2 □Cremation 4 □Donation 5 □ Other (S		Sac	ace of Dispo emetery, cre. red H	osition (Name of matory or other pla t. of Jes	sus Cem. 3	Date 3/8/2008		ocation - City or undalk,	Town, State Maryland
any injury or other traumatic event, the Medical Examiner must be notified at once. To Do Commission by Euroset Disease.		21. Signature of Funeral Service	Licensee	00	I	2. Name and Addr Ouda-Ruck 7922 Wis	Funeral	Home of	Dun	ndalk, I	nc. 1222
	4	23a. Part1 Inter the dise se, or sheek, or heart failure. List	complications that cause	d the death.						7 =	Approximate Interval Between
lical iner		Sequentially list conditions, if any, leading to immediate	Due to (or as								
burial-transit	ĭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1953) of high that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
for use as the bur	ĭ	cause. Enter Underlying Cause (Library and Particular Section 1997) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pf pregnan	ncy death 3[⊒Ectopic pregnand ⊒ Other (specify) _	ey			23d. Date of deli Month	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death 445 **Physician** 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Baltimore makulana Greneral 8. Date of Birth (Month, Day, . Social Security Number If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 140 - 46 - 9398 Usual Residence of Decedent 9. Birtholace (State or Foreign 6. Sex **Funeral** Months Days 1 M 2 Carolina Director 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 des 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Neyer Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Black Completed by 3 Widowed 4 Divorced Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
amply injury or other traumatic event, the Medical Exa
once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maide Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 19a. Infer mant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licen 23a. Part. In er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi e ause (Final disease i condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initious cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ones a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the the attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown ğ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 s autopsy 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🔲 Yes 2 ER/Outpatient 3 DOA within 24 hours after deaun.
To the Funeral Director: After this commietely filled in by the funeral director. Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/08 ٥ 30. Name and address of person who completed case se of death (Item_23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

MAR 11

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** CHARLES WILSON 5-30A M FEB /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTER LONG GREEN BALTINORE BALTINORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Dave Hours Min. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 216-30-8132 157 M 2 □ F Yrs. 73 MD March 1, 1934 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1x Yes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 Barcley Street 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💽 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Department of Heath and Mental Hygien Important: If item 27 is marked other the any Injury or other transment. social worker Dept. of Social Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles P. Wilson Razel Wilson 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Clark / cousin 6666 Collinsdale Road; Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. 03/11/2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA DAVIS /Medical Due to (or as a consequence of) DAYS Examiner INTRAVENTRICULAR BILATERAC HOE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DIFFUSE BRAIN Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending | 24 hours after death. Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 1

SHALLVANACA

DHMH 17 Rev 1/2001

9650

up He AID

COUPTA

32. Registiar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DOOS 3150

SANTIAGO RD

29d. Date signed (Month, Day, Year)

COWMBIIA

SUITELLA

NARCH 60 2008

NO ZIOY

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 or Attending Physician:

signed by the attending physician and After within 24 hours after death To the Funeral Director: in by t

28a-f show

6 Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Examiner must be notified

Certification: To

Medical

the Hospital State Registrar

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be determined

MYEJIAPA MO Hotselvica

31. Date filed (Month, Day, Year) FEB 2 8 2008

29b. Signature and title of certifier

3 ☐ Suicide

4 ☐ Homicide

(Check only one)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5

Ricardo /	Ashton		State of Maryland / De	epartment of Certificate of		Mental Hy		g. No.	20	08 078
	Physicia	an/	1. Decedent's Name (First, Middle,Last) RICARDO ASHTON				2. Date of Death Month February 2	Day Ye	əar	3. Time of Death 0718 hrs
Medical	Exami		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Lo	ocation of Death	rebluary 2	4c. County	of Death	
			North Branch Correctional Institution		Cumberland			Allegar	-	
	uneral irector		5. Social Security Number UNKNOWN 6. Sex 7. Age (In y	rs. last birthday) Yrs.	Months Days	If Under 24Hrs. Hours Min.	JULY 12			thplace (State or Foreign untry) HINGION, D.C.
	any	F	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location	on					10d. Inside City Limits
7		٦	MARYLAND ALLECANY (CUMBERLAND						1 Yes 2 No
Maryla	n me maylanu 3a or 28a-f sho otified at once.	Director	10e. Street and Number		10f. Zip Code			g. Citizen of V		ntry?
t d	123a ol notifi		14100 MMULLEN HIGHWAY SW 11. Marital Status 12. Was Decedent Ever	in U.S. 13. Was	21502 s Decedent of Hisp			NITED S		ican Indian, Black,
C and and and and and and and and and and	or deam w	Funeral	1 X Never Married 2 Married Armed Forces?	If Ye	es, specify Cuban, Yes $2 \mathbf{X} $ No	Mexican, Puerto		Wh	nite, etc. v: BLA C	x
	ours ar atural' caming	d by	15. Decedent's Education (Specify only highest grade complete	d) 16a, Decedent	t's Usual Occupation	n (Give kind of w		16b. Kind of	Business/	Industry
more, MD 21215-0036	ages I and 2 should be Itied Within 72 hours an 11 of Health and Mental Hygiene. 11: If item 27 is marked other than "natural other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12IH GRADE		PLOYED				ONE	
15-0	illed withing Hygiene. ed other the t, the Med	Be Co	17. Father's Name (First, Middle, Last) RICARDO PATRICK ASHION, SR.			8.Mother's Name				
2121	should be III and Mental I 7 is marked natic event,	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street					e, Zip Code)
Q S	of 2 shoulth and m 27 is aumati		FRIEDA EDWARDS / AUNT	3704 CF	RYSTAL LANE		IIIIS, MAI			Town, State
ore,	ges I and 2 s of Health a If item 27 ther traums		1 Burial 2 Y Cremation 3 Removal from State	crematory or oth	ner place)				•	
Baltimore,	permit. Fages 1 and 2 s Department of Health a Important: If item 27 injury or other traums		2 attree of Fig. 1 S L e 1	22. N	lame and Address	of Facility THO	ANION FUN	RAL HOM	E.P.A.	ALL, MARYLAND
	ysician	-	23a. Part I. Enter the disease, or complications that caused the disease.	leath. Do not enter th	he mode of dying, s	uch as cardiac o	r respiratory arr	est, shock, or	heart	20640 Approximate Interval
, .V	Acdical aminer	(i) (i)	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Heroin intoxi Due to (or as a consequer	cation_				-		Between Onset and Death
		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	and of):						
		Examine	cause. Enter Underlying Cause							
	te be executed ysician and burial - transit	al Exar	events resulting in death) Last Due to (or as a consequer							
	e be ex sician burial	edical	X UNPENDED ##5NDEB7,28a-f		7 3/12/08 7	T		23d. Date	of delive	TV.
3876	rtificate ing phy as the	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of	₂ Fe	etal death 3	Ectopic pregna	ancy	Month		Day Year
Š.	eath ce attend for use	sici	1 Yes 2 No 9 Unknown 9 Unknown	of death 5 Ot	ther (Specify)					
B	t the d	Phy	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause g	ven in Part I.	111		_	the cause of death?
o.	ires tha signed I be det	d by								obably 4 Unknown
ords	w requast been should	Completed	[]				24a. Was autop		b. Were a prior to death?	utopsy findings available completion of cause of
Rec	The la icate ha page 2	Som					1 Yes		1 🗸 Y	
ita :	ician: s certif rector,	Be (25. Was case referred to medical examiner?	2 ER/Outpatient		of Death (Check	only one)	Residence	6 Oth	er: Scene
) - -	g Phys fter thi reral di	: To	1 ✓ Yes 2 No 28a. Date of Injury (Month, Day, Year)	28b. Time of		y at Work?	28d. Describe			
uo.	tendin eath. Ior: A the fur	ation	1 Natural 5 Pending Fnd 2/24/20	008 Fnd 6:3	0 am 1 TY	es 2 X No	unk			
Division of Vital Records, P.O. Box 68760,	ospital or At hours after d meral Direct y filled in by	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury	- At home, farm, stre cell	et, factory, office b	uilding, etc.	28f. Location (or Town, S Institu	Street and Nu State) Nort tion, <u>Cu</u>	mber or R h Brai mber1:	Rural Route Number, City INCH COTTECTIO AND
:	To the flospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	edical C	29a. Certifier 1 Certifying Physician: To the best of my knot one) 2 Medical Examiner: On the basis of examina	owledge, death occu tion and/or investiga	rred at the time, da	te and place, and death occurred	d due to the cau at the time, date	se(s) and mar and place, ar	ner as stand	ated. the cause(s)
	7. w C	Me	29b. Signature and title of certifier		29c. Licens					lonth, Day, Year)
			auas2-		O.C.1	И.Е.		Februar	y 25, 20)08
N	В		30. Name and address of person who completed cause of death Ana Rubio MD. Assistant Medical Examine	r 111 Penn S	Street, Baltimo	re, MD 2120	1			
		tate	31. Date filed (Month, Day, Year) MAR 0 6 2008 32. Resistrar's S	ignature,	all					
	wegn	416	MAIN V V V							

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

24 hours after death e Funeral Director: filled in by

(Month, Day 17 Natural 5 Pending investigation M 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 ☐ Yes 2 ☐ No

29c. License number

D22309

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) February 26, 2008

February 26,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Oll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8712 Maywood Avenue, Silver Spring, MD 20910

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008

MD

29b. Signature and title of certifier

Philip Poth,



To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		,	Cei	rtificate of	Death	F	Reg. No.	2008	07877
	- 法		1. Decedent's Name (First, Midd.	le, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		Catherine Wi	inifred Ar	geluz	zi			MARCH	4	2008	07:53 A ^M
	Examin		4a. Facility Name (If not institutio	n, give street and number	er)		4b. City, Town,	or Location of Death		4c. C	ounty of Death	
			St. Mary's Hos	spital			Leonard			St	. Mary'	S
	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n v, Year)	9. Birthp	lace (State or Foreign
- 8	Director		194-12-7951	1 LIM 2 LANF	84	Yrs.			07/26/1	923		ýlvania
	pu »		Usual Residence of Decedent 10a. State 10b. County	,	10c Cit	y, Town or Lo	ncation				1	0d. Inside City Limits
	anyla shov d at	ž										1 ☐ Yes 2X No
	he M 18a-f otifie	ectc	Maryland St. Ma	ry's	Lexi	ington				10 0:::	- of 14/h at Court	
	vith t	Ö	10e. Street and Number				10f. Zip Code			Ü	n of What Cour	
	s 23	ra	23198 Barley (-4 C i - 11	0 10	20653	Uinnania Orining (Co			ed Stat	
	er de Item ner n	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Decede Armed Force rried 1 ☐ Yes 2	nt⊑verin o. S? XiNo	.5.	If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	o Rican, etc.)	'	Black, White,	
36	72 hours after death with the Maryland inatural", or Items 23a or 28a-f show dical Examiner must be notified at	by F	3 X Widowed 4 □ Divorced	If Yes, Give			1□Yes 2XINo	Specify:		s	Specify: Whi	to
ş	tura sal E			nt's Education		16a. Dece	dent's Usual Occu	pation	= 1	16b. Kind	will of Business/In	
15	nin 72 n "na Media	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4d	or 5±)	(Give life.	kind of work done DO NOT use retire	e during most of work ed)	king			
212	y with	Completed	Lienie hary/Secondary (0-12)	2	л <i>э</i> +)	Homem	aker			Own :	Home	
þ	e filec al Hyg othe /ent,	Be C	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	ne (First, Middle,	Maiden S	urname)	
<u>'a'</u>	ald be denta rked tic ev		John Joseph Beg	gley				Agnes Mc	Nulty			
ary	short short	Ĺ	19a. Informant's Name/Relations	ship (Type. Print)		19b. Maili	ng Address (Stree	et and Number or Ru	ral Route Numbe	er, City or T	Town, State, Zip	Code)
Σ	and 2 alth 27 i	11 1	Kenneth J. Ange	eluzzi/Son				Court, Le	xington	Park	, MD 2	.0653
Baltimore, Maryland 21215-0036	permit, Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation	0 D D	20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Loca	ation - City or To	own, State
Ĕ	Page nent int: If		4 □ Donation 5 □ Other (Bri	insfie]	ld-Echols	s Cre 03/0	5/2008	Char1	otte Ha	11, MD
att	permit. Departn Importa any Inju	1	21. Signature of Funeral Service	License		2:	2. Name and Addr	ress of Facility Bri	insfield	Fune	ral Hom	ne. P.A.
Ω	on an in	(6) (1)	Kyle S. Simo	ons M01206				Lywood Roa				20650
	2.		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause only one cause on each	sed the deat	h. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
0	Physician	1	Immediate Cause (Final disease or condition		0	gen i	5	hock			i i	Onset and Death
	/Medical		resulting in death)	Due to (or	as a conse	ence of):	1		0 /		0	
- 6	Examiner		Conventiolly list conditions	, Ca	rdia	C	Arra	est -	Prolon	ged		
1	P #	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of).	0	1	\sim ℓ			
	rifficate be executed ng physician and s as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. Acu		myo	carolio	est -	aret	on		
N 0	e exe		resulting in death) Last	Due to (or	as a conseq	juence or):		J				
5 2 2	ate b	Medical		d								
~	± 50 €		IF FEMALE:	22a If you guiden		0001						-
Box	death ce e attendi d for use	Physician/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	n 2 □ Feta	aldeath 3[⊒Ectopic pregnan	су		23	ld. Date of deliver Month	ery Day Year
2)0	ne de the a	/sic	1 ☐ Yes 2 2 No 9 ☐ Unknown	4□Pregnan 9□Unknow		ieatn 5L	Other (specify)					
00	w requires that the death ce been signed by the attendit should be detached for use	Ph	Part II. Other significant condit	ions contributing to deat	h but not res	sulting in the u	inderlying cause g	iven in Part I.	23e. Did to	bacco use	e contribute to t	he cause of death?
S.	ires t signe	by		July 30 miles		g	g g		1 🗆 \			- ·
A Po	requires reen sign hould be	ited										
Record	e law has b e 2 sl	Completed							24a. Was autop	sv	prior to co death?	psy findings available mpletion of cause of
Ø ±	The cate ha	Co							1□ Yes	rmed? 2 X No	1 Yes	2 No
Vital	ician Sertifi ector	Be	25. Was case referred to medic examiner?	Happital			10	26. Place of Dea				
or or	Physician: this certificatal director, i	ို	1 Yes 2 No	28a. Date of		28b. Time o	. O D D O / 1		ome 5 Resid			(y)
Ð E	ding Physician: The lav n. After this certificate has funeral director, page 2.	<u></u>	1 Natural 5 □ Pendi	ing (Month,	Day Year)	Injury	W	ork? □Yes 2∐No	Zou. Describe r	iow injury	occurred	
the	ttend death stor: the	cat	3 Suicide 6 Could	tigation	injuny - At h	ome farm et	reet, factory, office		28f Location (9	Street and	Number or Bur	al Route Number,
≯ .≧	or A after of Direction by	Certification:	4 ☐ Homicide determ	mined 288. Flace of building	etc. (Special	fy)	root, ractory, office		City or Tou	vn, State)	rearribor or riare	ar riodio (varibor,
4	pital ours a eral filled		29a. Certifier 1 Certify	ing Physician: To the be	est of my kno	owledge, dear	th occurred at the	time, date and place	and due to the	cause(s) a	and manner as s	stated.
C	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medica one)	i Examiner: On the basi and manner	s of examina	ation and/or ir	nvestigation, in my	opinion, death occu	urred at the time,	date and	olace, and due t	o the cause(s)
	o the	Me	29b. Signature and title of certifi	er /	. /	1	29c. Licer	nse number		29d. Date	signed (Month,	Day, Year)
	On.		1 Hand	C-A1	/	M	D2.	5230		•	3-4.	08
	PC.		30. Name and address of person	n who completed cause	of death (Iter	m 23a) (Type,	Print)					
	. 10		David Allen, N	4.D. 25500	Point	Looko	ut Road.	Leonardt	own. MD	206	50	
	Sta		31. Date filed (Month, Day, Year	r)32. F eg	istrar's Signa	ature						
- 1	Regist	ar	V APPIRE	- 2000	me i	S A	mede					
						-						

DHMH 17 Rev 1/2001

T .	Phy /N Exa	vsicia: ledica amine	
LIVISION OF VITAI RECORDS, P.O. BOX 68/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours of process.	To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	
	- /		

		State of Maryland / Department of Health and N 1 - State Registrar AMEND#13/perFH3-3-08, BMV, Modo Certificate of Death	Mental Hy		2008	07878
ALC: E	22	Decedent's Name (First, Middle, Last)	2. Date of D		V	3. Time of Death
Physici /Medi		Perry L. Brown	Month Februa	Day ry 2!	Year 5, 2008	5:48 p ^M
Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c.	County of Death	
		1813 Chapel Hill Road Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bi	rth	Montg	
Funeral Director		222-24-6717 We M 2 F 66 Yrs. Months Days Hours Min. Usual Residence of Decedent	Nov. 1	ay, Year)	941 Del	lace (State or Foreign htry) aware
ryland how		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
ne Ma 8a-f s otiflec	Director	Maryland Montgomery Silver Spring				1 □Yes 2 No
with the		10e. Street and Number 1813 Chapel Hill Road 20906		10g. Citiz	zen of What Cour USA	itry?
ns 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or N	0-	14. Race - Americ	
72 hours after death with the Maryland natural", or Items 23a or 23a-f show disal Examiner must be notifled at	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puèrto 1 Yes, Sive 1 Yes, Sive Year or Dates: If Yes, specify Cuban, Mexican, Puèrto 1 Yes, Sive Year or Dates:	Rican, etc.)		Black, White, Specify: Bla	
72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king	16b. Kir	nd of Business/Inc	dustry
within ene. than he Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Analyst		Priv	vate	
e filed Il Hygi other ent, t	Be Co	13 Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle	e, Maiden	Surname)	
uld be Menta arked artic ev	To B	Sydney O. Brown Elise Ran	ndolph			
Pages 1 and 2 should be filed within 72 he nent of Health and Mental Hygiene. nt: If item 27 is marked other than "naturity or other traumatic event, the Medical		19a. Informant's Name/Relationship (Type. Print) Dave Ferebee/Brother 19b. Mailing Address (Street and Number or Run 1813 Chapel Hill Road				
Pages 1 sent of He nt: If iten ry or oth		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			cation - City or To	
permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins	Funera	ıl Hor	me Inc.	Virginia
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			ver spri	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Acute Myocardial Infarction				Onset and Death
/Medical Examiner		Due to (or as a consequence of):			i	
	Jer	Sequentially list conditions, than, leading to immediate b. Coronary Artery Disease Leis to (or as a consequence of):				
ecuted nd transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
icate be executed physician and s the burial-transit		Due to (or as a consequence of):				
, -	edical	d.				
The law requires that the death certific the has been signed by the attending page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		2	23d. Date of delive Month	ery Day Year
ires that the de signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
w requires been sign should be	ed by		1 🗆	Yes 2[□ No 3 □ Prob	pably 4 [™] Unknown
The law recate has been page 2 sho	Completed		per	s an opsy formed? 21 No	prior to co death?	ppsy findings available mpletion of cause of
ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			1	
ding Physician: After this certific funeral director,	မ	1 ☐ Yes XXNO	ome 5 🗷 Res		6 Other (Special	(y)
ding F h. After funer	tion:	27. Manner of Death 1 Stratural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	28a. Describe	now injur	y occurred	
or Attending Physician: a re death. Urector Affer this certifics in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and own, State	d Number or Rura)	al Route Number,
To the Hospital or Attendin within 24 hours aller death. To the Funeral Director Art completely filled in by the fur	ledical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
	Me	29b. Signature and hitle of certifier 29c. License number	2817		te signed (Month, uary 26,	
10		30. Name nd a dress of persor who completed cause of death (Item 23a) (Type, Print) M. Wajeed Khan, MD 12016 Georgia Avenue, Wheaton, M	D 20903	2		
Sta	ate.	31. Date filed (Month, Day, Year) 22. Registrar's Signature				
Regist		31. Date filed (Month, Day, Year) 2. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, 19b per 1h g87/ 3-14-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Robert Brandt /Medical FEBRUARY 25, 2008 6:30P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GLADE VALLEY REHABILITATION WALKERSVILLE FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 88 Yrs. 350-09-5854 Director 06/06/1919 ILLINOIS Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits at a or 28a-f sho be notified a Director 1 X Yes 2 No MDFREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24-"natural", or items 23a 102 MERCER COURT APT 25-5 Funeral 21701 Examiner must U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 XYes 2 No If Yes, Give Year or Dates: WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **ENGINEER** U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည ISADORE BRANDT PEARL LEVY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
102 MERCER COURT APT 25-5, FREDERICK, MD 21 19a. Informant's Name/Relationship (Type, Print) EDITH T. BRANDT - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEML GDNS 02/27/2008 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC
1091 ROCKVILLE PIKE, ROCKVILLE, MAR 21. Signature of Poner 1.8 rvice Licensee EDWARD SAGEL FUNERAL DIRECTI 1091 ROCKVILLE PIKE, ROCKVIL

23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20852 MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dneumonia Days /Medical Due to (or as a of nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown mellitus 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1∐ Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 051643 Hiron 5hch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hirenkumar N. Shah, M.D.

Registrar

State

31. Date

Fredorick

32 registrar's Agnature

Thomas

Month, Day, Year) FEB 27

			For State Registrar	State of Maryla		artment of F rtificate of		nd Me		giene 2 (Reg. No.	008	0788
e z F	Physici /Medio		1. Decedent's Name (First, Middle, Last SANCLA C. T	, Beit				2	Date of De Month	Day	Year 8	3. Time of Death 9! 25 (
	Examir uneral rector		Social Security Number 6. Se	care Cent	rs. last birthday) Yrs.	4b. City, Town, o Garth If Under 1 Year Months Days	ersb.	Hrs. 8.	Date of Birt (Month, Da	Mon	Couit	place (State or Fore
ъ	-	V.	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	cation		U	une 14	1940		10d. Inside City Limi
the Mary	28a-f sh notified	rector	Maryland Me	ontgomery	Ве	hesda 10f. Zip Code				10g. Citizen of	What Cour	1 ☐ Yes 2% ☐ M
with	3a or	Ö	5505 Roosevelt	Street		208	17			US		y.
d 6.16.10000 filled within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		n? (Specif Puerto Rid	y Yes or No- an, etc.)	14. Ra	ce - Americ ack, White,	
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	PAR		23a. Part I. E. ter the disease, or composhock, or heart failure. List only o		eath. Do not ent	er the mode of dyir	ng, such as ca	ardiac or r	espiratory a	rest,		Approximate Interval Between Onset and Death
	sician edical	86 6	Immediate Cause (Final disease or condition resulting in death)	a		Ovania	n Ca	ince	r			Oliset and Death
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			30. Name and address of person who co	COVE OF		Faz		Mi	7	-, Ο α	MD	2087
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DHMH 17 Rev 1/2001

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Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs. Ia	ast birth	nday)	If Under Months		If Under Hours	24Hrs. Min.			Birthplace (State or Foreign Country)
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To the within 2 To the Complet	Medical	29b. Signature ar		and manner	stated.					e number				(Month, Day, Year)
	آ ا	- Signatura ar	A	() ()	\cap				O.C.	M.E.			March 5, 20	08

State 31. Date filed (Month, Day, Year)
Registrar MAR 0

MAR 0 7 2008

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Laron Locke MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 5, Physician William Norman Balm 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 218 Norva Avenue Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) December 3, 1914 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠ M 2□ F 93 Pennsylvania 160-09-765 Usual Residence of Decedent **Director** 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene.
artment of Health and Mental Hygiene.
Tratural: If them 23a or 28a-f show from "natural", or items 23a or 28a-f show in order traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 Norva Avenue 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No World
If Yes, Give
Year or Dates: War II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Leather 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be final that and Mental H Edward Balm Axia Ann Mercer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine L. Balm / Dauther 218 Norva Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of Rescharge) Reschargen Memorial Gardens 20a. Method of Disposition March Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11, 2008 22. Name and Address of Facility Keeney & Basford P.A. Funeral 21. Signature of Funeral Se M01433 106 E. Church St., Frederick, MD 21701 Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congentive disease or condition resulting in death) -2WECK /Medical Due to (or as a conse pence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 1 ☐ Yes 2 No 1□ Yes Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Natural Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers of who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

			For State Registrar	State of Marylar	•	tificate of		Re	eg. No. 20	08 07883
г	Physici	an	Decedent's Name (First, Middle, Last					Date of Deat Month	Day Y	3. Time of Death
	/Medic		Maxine Barbara	Brow		41. Cit. T	1	Februar	-	008 8:55 p ^M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of	
303		At 2	St. Mary's Nursing 5. Social Security Number 6. S		last birthday)	Leonard		8. Date of Birth	St. Mar	Cy S D. Birthplace (State or Foreign
	Funeral Director			□ M 2 🗓 F 9.	Ven	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/14/1	916 M:	Country) ichigan
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	to	Maryland St. Mary	's Ho	llywood					1 □Yes 2 X No
	r 28a	Director	10e. Street and Number		LLywood	10f. Zip Code	_	1	0g. Citizen of Wh	at Country?
	h with		24050 Dudley Cour	t		20636		11	nited St	ates
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.\		dispanic Origin? (Spe an, Mexican, Puerto I		14. Race -	American Indian, White, etc.
9	after or its	E/	1 Never Married 2 Married	1 ☐ Yes 2 🔏 No If Yes, Give		I∐Yes 2∭ No		noan, oto.)	Specify:	winte, etc.
21215-0036	nours ural",	d by	3 AWidowed 4 □ Divorced	Year or Dates:					1	White
5-	"nati	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	lent's Usual Occup kind of work done	oation <i>during most of workii</i> d)	ng	16b. Kind of Busi	ness/Industry
12	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem		u)		Orm Home	
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ary.	should ind Men inarke	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	g Address (Street	and Number or Rura		, City or Town, S	tate, Zip Code)
	and 2 ealth a n 27 Is ier trai		Carl Brow/Son		24050	Dudley (Court, Hol	lywood.	MD 206	536
Je,	s 1 a		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other pla	ce)			ity or Town, State
Baltimore,	Pages nent of I unt: If ite		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State 1			Cem 3-06-	-2008 F	lat Rock	k, Michigan
alti	permit. Page Department Important: If any Injury of		21. Signature of Funeral Service Licen		12 0 22	. Name and Addre				Home, P.A.
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68760,	rtificate be executed ig physician and as the burial-transit	edical		d						
	certif nding Jse a	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr					23d. Date	of delivery
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ž	The lav	E						autops perforr 1□ Yes	med? de	ior to completion of cause of eath? □Yes 2□ No
<u>ta</u>	ilclan: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			
	Physician: r this certific ral director,	TO E	1 Yes 2 1 No	Hospital: 1 ☐ Inpatient 2	BR/Outpatien	t 3 DOA Oth	ner: 4.XiNurs i ng Hor	me 5 ☐ Reside	ence 6 □Other	(Specify)
Division or	ding Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at 2 rk?	28d. Describe ho	ow injury occurred	d
Sio	Attending r death. ector: After by the fune	Certification:	2 Accident investigation]Yes 2□No			
Ë	or Attendafter death Director:	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At I building, etc. (Spec	nome, farm, str sify)	eet, factory, office	1	28f. Location (St City or Town	treet and Number n, State)	r or Rural Route Number,
	oital ours at		00 0 45 470 471 51	To the best of the	and declar					and the state of
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kr nlner: On the basis of examir and manner stated.	nation and/or in	vestigation, in my	opinion, death occurr	ed at the time, d	ause(s) and man late and place, ar	nd due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and tille of certifier	and manner stated.		29c. Licens		2	9d. Date signed	(Month, Day, Year)
\	⊢≯⊨ŏ		/ / / A		MD		12096		2-28	-08
	~		30. Name and address of person who	completed cause of death (Ite	m 23a) (Tyne	Print)				
لل	(Je)		RATBINDEA	- S. GiL	87	14H A	siccin TES	, Hore	Yubor)	MD 4036.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1 3				
	Registi	ar	MAR 0 S	2008	M.	growth .				MD 2036.
DI	MAIL 47 Day 4/0	004		10						

			1 - For State Registrar	State of Ma	aryland		irtment of H		nd Mental H	ygiene Reg. No	711	08	07881	
١			Decedent's Name (First, Middle, La	st)					2. Date of	Death			3. Time of Death	
	Physici		George	Robert	Brov	רוזע			March	Da	2008	Year	1:15 p M	
	/Medic Examin		4a. Facility Name (If not institution, give		BLOV	N III	4b. City, Town, or	Location of			. County o	f Death	1.13	
			Charlotte Hall	Veterans Ho	ome		Charlo	tte Ha	a11		St.	Marv	's	
	Funeral		Social Security Number 6.5	Sex 7. Age	e (In yrs. la	st birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of I	Birth Day, Year			lace (State or Foreign	
	Director		510-14-2704	1∰ M 2□ F	84	Yrs.	Days	Tiodis	Sept.			Kans		
	p .		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation		-			1	Od. Inside City Limits	
	anyia ho	č	Tou. Glato				oation						1 ☐ Yes \$₹☐ No	
	the N	Director	Maryland Talbo		Ea	aston	10f. Zip Code			10g. Citizen of What Country?				
	with	ā		• • • • • • • • • • • • • • • • • • • •				(01		log. Ci			my r	
	death with the Maryland me 23a or 28a-f ehow rroust be notified at	era	1175 South Wash:	12. Was Decedent		. 13. \		601 Ispanic Orig	in? (Specify Yes or	USA				
20	y within 72 hours after death with the Marylan jiene. r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give			fYes, specify Cuba I□Yes 2⊊ No	n, Mexican, Specify:	in? (Specify Yes or i Puerto Rican, etc.)		etc. Thite			
-003c	hour ture!	d be	15. Decedent's E	Year or Dates:	1	163 Dooo	lent's Usual Occupa	ation		16h k	(ind of Bus	inocc/loc	ductor	
Ċ	within 72 ene. then "nai	Completed	(Specify only highest gr	ade completed)		(Give	kind of work done of NOT use retired	during most	of working	100. 1	Cilità di Dus	111622/1110	austry	
7	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5 4	i+)		tircal E			In	terna	tion	al Sales	
0	E P E E	Be C										n Sumame)		
land	id be enta ked ked	To B	George Charles Brown Gladys Richards									s		
Mary	s 1 and 2 should f Heaith and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street a	and Number	or Rural Route Nun	ber, City	or Town, S	tate, Zip	Code)	
_	1 and 2 Health em 27 i		Ann B. Freeman/1	Daughter		4 Dun	es Terra	ce, Le	ewes, Dela	ware	1995	8		
ore	of Head of Head fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Pla	ice of Dispo metery, crem	sition (Name of natory or other plac		Date		ocation - (
aitimo	Pag ment ant: i		4 Donation 5 Other (Speci		Bri	nsfiel	d-Echols	3	3/3/2008	Cha	rlott	е На	11, MD	
Dall	permit. Pages Depertment of Important: If if ony Injury or c		21. Signature of Funeral Service Luc	// //	100817	7 Br	Name and Addressinsfield	Echol	s Funeral	Hom	e, P.	A. ail.	MD 20622	
ī			23a. Part1. Enter the disease, or com	plications that caused	the death.								Approximate Interval Between	
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each in		187	108	SEN	CATIG				Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as	a conseque	ence of):	150	201	(2011)					
	Examiner		Conventially list conditions	b										
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	_				-			
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c										
Ď,	cate be execut obysician and the burial-trar	al E		Due to (or as	a conseque	ence or):								
09/80		dical	•	_ d								-		
XOC	death certific e ettending p id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	су					23d Date	of delive	nov.	
Ď	leath etter	ciar	in the past 12 months?	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year						
į	the c by the achec	hysi	9 Unknown	9□ Unknown										
r.	requires that the leen signed by th hould be detache	y P	Part II. Other significant conditions	contributing to death bi	ut not result	ting in the ur	nderlying cause give	en in Part I.	23e. Di	d tobacco	use contri	bute to th	ne cause of death?	
Ë	quire en sig		CHRONIC	OBSTE	2 UCT	NE 1	VLMONA	ry 1)1.	SGAS\$ 10	☐ Yes 2	!□No :	3 🗌 Prob	ably 4 Unknown	
ecoras,	law re as ber 2 sho	Completed	1+4P 827	GNSION'					24a. W	as an topsy	24b. W	ere auto	psy findings available impletion of cause of	
	The The page	E O							pe 1 □ Yes	rformed?	de	eath?		
VII	ysicien: The law requires that the death is certificate has been signed by the ette director, page 2 should be detached for	BeC	25. Was case referred to medical examiner?					26. Place	of Death (Check onl	-				
	G is	2	1 ☐ Yes 2 No	Hospital: 1 _ Inpatie		R/Outpatien		4 K NAMI	sing Home 5 ☐ Re	sidence	6 □Othe	r (Specify	v)	
	Ing P	ino i	27. Manner of Death 1 Naturat 5 □ Pending	28a. Date of Injur (Month, Da)	Year) 2	28b. Time of Injury	28c. Injury Work		28d. Describ	e how into	iry occurre	d		
<u> </u>	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□N		/Ct-==t =	and Alicentic	s os Over	/ Courte Marches	
DIVISION OF	effer of Direct of in by	Certification:	4 ☐ Homicide determined	28e. Place of Injubuted building, etc	c. (Specify)	ne, tarm, str	eet, ractory, office			own, Stat		r or Hura	il Route Number,	
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	Medical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination	ledge, death	occurred at the time	ne, date and pinion, death	place, and due to the control occurred at the time	ne cause(s	s) and man	ner as si	tated.	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	IIOO.		29c. License			,			Day, Year)	
)	N 2 + 3 + 3		0 1	2.4.0			DAR	818	700	1	2/	,21.	2	
	XX		30. Name and address of person who	completed cause of d	eath (Item 1	23a) (Tyne	Print)	000	152		2 10	1-1	2000	
	,10		NAZNIN	ESPHAN	11,00	16)		tte Ha	all, MD 20	622				
	Sta		31. Date filed (Month, Day, Year)	Registra	ar's Signatu	ire	Re							
	Registr	ar .	MAR 0 5 20	108	e St	A STATE OF								

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4			1 - For State Registrar	State of Maryl		artment of H		P	leg. No.	8 07	885		
	Physicia	an	Decedent's Name (First, Middle Carmen	e, Last) Louis	Bishop			2. Date of Dea Month Mar 5,	2008	Year	of Death		
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)	Візпор	4b. City, Town, or			4c. County of Death				
	~		Allegany County 5. Social Security Number	y Nursing Home	yrs. last birthday)	Cumberl If Under 1 Year	and If Under 24 Hrs	s. 8. Date of Birth	Allega		te or Foreign		
	Funeral Director		212-38-6113 Usual Residence of Decedent	1 k M 2 □ F 70	Yrs.	Months Days	Hours Min		, 1938	9. Birthplace (State Country) MD			
	aryland show	_	10a. State 10b. County	gany	c. City, Town or Lo Cumi	perland		10d. Inside City Limits 1 ☑ Yes 2 ☐ No					
	the M	recto	10e. Street and Number	,		10f. Zip Code			10g. Citizen of W				
	th with 23e or	al Di	730 Furnace St	reet		2	21502		US	Α			
920	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or tems 23e or 28e-f show do other than "natural" or tems 23e or 28e-f show event, the Modical Examination in the codified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes Give		Was Decedent of Hi If Yes, specify Cuba 1☐ Yes 2 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black	- American Indian c, White, etc. white	,		
Maryland 21215-0036	thin 72 ho e, an "natur Medical	Completed		t's Education st grade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of w		16b. Kind of Bus	siness/Industry			
2	filed wi Hygien other th	Co	12 17. Father's Name (First, Middle,	(ast)	labore	r	18. Mother's Na	ame (First, Middle,	CSX Rail				
yland	e d a la be	To Be	Matthew Sab	ers			Nondis	P. Miller	Sabers				
Mar	5 K M		19a. Informant's Name/Relations Joseph Bishop	hip (Type, Print) brother	19b. Maili 224 I	ng Address <i>(Street a</i> E. Mary Stree	and Number or F et		erland	or Town, State, Zip Code) and MD 21502			
Baltimore,	perrit. Pages 1 and Department of Heall Importent: if Item 2 any injury or other 2005.		20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from State	ob. Place of Dispo cemetery, cre St. Mary's C	matory or other place	9)	3/8/2008	20c. Location - C	City or Town, State rland	MD		
Balti	pernit. Dep. rtm Importe any inju		21. Signatury of Funeral Service		2	2. Name and Address Scarpelli		Home, PA Je: Cumberl	land MAD O	4500			
Fny. /Mo Exa	ate be executed //Medical Examiner the burial-transit	i Examiner	23a. Part1 Enter the disease of thook, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exter urdanying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPS Due to (or as a conductor) Due to (or as a conductor) Due to (or as a conductor) Due to (or as a conductor)	nsequence of): L nsequence of):	ter the mode of dying	g, such as cardi	ac or respiratory ar	rest,	Approxir Interval I	mate Between nd Death MOS		
P.O. Box 68760,	t the death certific by the attending p ached for use as	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year				
ds, F	rires that signed b	ρ	Part II. Other significant condition	ons contributing to death but no		underlying cause give	en in Part I.	23e. Did to		ibute to the cause 3 Probably 4			
Records,	he law requir e has been si age 2 should	Completed							rmed? d	Vere autopsy findin rior to completion o eath? ☐ Yes 2 ☐ No	igs available of cause of		
Vital	ien: T	BeCc	25. Was case referred to medica examiner?	ıt			26. Place of D	1 ☐ Yes eath (Check only o					
	To the Hospitel or Attending Physicien: The I within 24 bours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	မ	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yei	2 ER/Outpatie 28b. Time of Injury	of 28c. Injury Work	4 🗷 Nursing	Home 5 Resid	dence 6 Dothe				
Division of	ii or Atten after deal I Director: d in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 399 Place of Injury		reet, factory, office		28f. Location (S City or Tox	(Street and Number or Rural Route Number, own, State)				
	To the Hospitei within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medicel	ng Physicien: To the best of my Exeminer: On the basis of exa and manner stated.	y knowledge, dea mination and/or in	th occurred at the tin	ne, date and place pinion, death oc	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the caus	se(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifie		\cap	29c. License	e number		29d. Date signed	(Month, Day, Yea	ir)		
1			Mobersto	ano y. Ban	ex. /	D-	1480	05	MARC	# 6-	2008		
			30. Name and address of person	who completed cause of death BARERA	(Item 23a) (Type	n. HOSP	MED.	BLDG, (Luns.	moa	1502		
	Sta Registi		31. Date filed (Month, Day, Year, MAR 1	2 2008 32. Begistrar's		bert							

Physician /Medical **Examiner**

certificate be executed

P.O. Box 68760,

Records,

or Vital

Division Attending **Physician**

/Medical

Examiner

10a. State

Funeral

Director

d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

2 should be filed within 72 tand Mental Hygiene.

Is marked other than "nat

ages 1 and 2 should bent of Health and Ments it if Item 27 is marked y or other traumatic e

permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Baltimore, Maryland 21215-0036

Funera

Completed

Be

Examine Physician/Medical as Completed

Be

2

Certification:

Medical

29a. Certifier

burial-transit and attending physician the nse for ned by the a detached for

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner?

24a. Was an autopsy performe 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident 3 Suicide 4 ☐ Homicide

6 Could not be determined

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b, Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 00065086

Tectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 02/20/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carron o- nomesty

Hospital:

28a. Date of Injury

WE INVESTIGAT, NW SIME 415, WASHINGTON DE 2000

State Registrar

completely filled in by the funeral

s after death.

hours Funeral

To the Ho within 24 h To the Fu

31. Date filed (Month, Day, Year) FEB 2 8 2008



DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) FFB 27

2008

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Ricardo Ayala-Car	1	- For State	St	ate of	Marylaı			ment of <i>licate of</i>			Menta	al Hyg		Reg. No.	2	00	8	0788
Physician Medical Examine	1/	Registrar 1. Decedent's Name Ric	(First, Middl ardo	e,Last)	Aya	la		Cam	acho)			. Date of De Month February	23, 20			3. Time (0927	
R.M.		4a. Facility Name (if 10021 Lorair							Silve	r Spring				N	. County of Montgom	ery		
Funeral Director		5. Social Security No none	umber	6. Sex		7. Age (In yr		birthday) Yrs	Month	er 1 Year ns Days	If Under Hours	Min.	8. Date of B		972	Foreign Cou	eyi	CO
d how any			1. State 10b. County 10c. City, 10m of Eccation									de City Limits es 2 X No						
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Director	10e.Street and Number 10021 Lorain Avenue							10f. Zij	209	01			_	g. Citizen of What Country? Mexico			
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Marrie 3 Widowed		arried 1	2. Was Dece Armed Fo Yes Yes, Give Year	rces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.							etc. W	nerican Indian, Black, c. White			
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after d nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	Completed by	15. Decedent's Ed Elementary/Seco			nighest grad College (1		d) 1	6a. Deceder	nt's Usua nost of wo	Occupati orking life. rpen	on (Give ki DO NOT L ter	ind of wo	rk done d)	C	6b. Kind of Business/Industry Construction			n
1215-00 be filed wi ental Hygien rrked other	B	17. Father's Name (First, Middle, Last) Rodolfo Ayala								18. Mother's Name (First, Middle, Maiden Surname) Maria Camacho Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 0 Eagle Crest Village Lane Roswell, G							10076	
MD 21 nd 2 should alth and Ms m 27 is ms aumatic e	2	19a. Informant's Na Juan Ca 20a. Method of Disp	rlos			othe	r On Pic	609	Eag	le C	rest	Vi	11age	∋ La	ane R	osw	ell	,GA.
Baltimore, MI permit Pages I and 2 a Department of Health a Important: If item 27		1 X Burial 2 4 Donation 5	Crematio	gecify:		m State	cre	ematory or of icipa	ther place 1 C	emet	ery		1/200	1 8C	Hidal Mexi	go co	Mic	hoacan
		21. Signature of Fu	NEW	all s		aused the de	eath. [laa	11	C0111	mhia	R1	FUNI vd_Si	i 1 we	r Sn	rir	Appro	ximate Interval
Physician Medical xaminer		failure. List on Immediate Cause (or condition resulting	ly one cause Final disease	e on each e a. <mark>C</mark> a	line. Irdiomega to (or as a	aly											Betw	een Onset and Death
	ner	Sequentially list co if any, leading to in cause. Enter Under	nmediate		e to (or as a	consequen	ice of):											
	l Examine	(Disease or injury t events resulting in	nat initiated	C.	e to (or as a	consequen	nce of):											
be es	Medical	UNPENDED			AMENDED 23c. If yes,	outcome of	pregna	ancy						2	23d. Date of			
Division of Vital Records, P.O. Box 68760 within 24 hours afterding Physician: The law requires that the death certificate I To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the burnel of the funeral director, page 2 should be detached for use as the burnel.	siciar	23b. Was decedent past 12 months	s? No 9 🔃 Ui	nknown	9 Unkn	ant at time		th 5 C	etal deat Other (Sp	ecify)		pregnai			Month		Day	Year
s, P.O. I	ed by Phys	Part II. Other sign	ificant cond	itions co	ontributing to	death but	not res	sulting in the	underlyi	ng cause (given in Pa	art I.	1 🗀	Yes 2	No 3	Pro	bably 4	e of death? ✓ Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director, page 2 should be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a se	Completed												1 ✓ Ye	as an utopsy erformed es 2	?	orior to death?	completi	ndings available on of cause of
ician:	Be	25. Was case refer examiner?	red to medic		pital:	Inpatient :	2 1	ER/Outpatier	nt 3	26.Place	of Death Other		g Home 5	Resi	idence 6	✓ Othe	r: Scene	
Division of Vital Rec nothe Hospital or Attending Physician: The levithin 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	ion: To	1 Yes 27. Manner of Dea 1 Natural		nding	28a. Date			28b. Time of		28c. Inju	ry at Work	·?			injury occur			
Divisic tal or Atte tra after dea arl Director	Certification:	2 Accident 3 Suicide 4 Homicide	6 Co	estigation uld not be ermined	28e. Plac (Specify)		- At hor	me, farm, str	eet, facto	ry, office	building, et	tc.		n (Stree		er or R	ural Rou	te Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier	Certifying Medical Ex	aminer:0	: To the be	of examinat	wledg tion an	e, death occ d/or investig	urred at t ation, in	he time, d	ate and plan, death oc	ace, and courred a	due to the o	ause(s)	and manne place, and	r as sta due to t	ted. he cause	e(s)
£ 2 £ 8	Me	29b. Signature and	title of certi	ier hall	mA				2		se number				d. Date sign ebruary 2			y, Year)
		30. Name and add Pamela E.			mpleted cau Assistant				11 Per	n Stree	et, Baltin	nore, N	/ID 21201					
St: Regist	ate	31. Date filed (Me	Bay, Kea	7 200	8 32.4	egistrar's Si	ignatu	2 /4	orth	9								

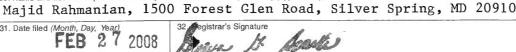
			1 - For State Registrar	State o	f Marylan	-	artment of F ctificate of a		Mental Hy	giene Reg. No.	008	07890	
3	Physici	an	1. Decedent's Name (First, Midd	le, Last)					2. Date of D	eath Day	Year	3. Time of Death	
	/Medic		Anna Theresa	DeRosa					Febru		5 2008	1002 AM	
1	Examin	er	4a. Facility Name (If not institution	n, give street and nur	mber)		4b. City, Town, o	r Location of Dea	ath	4c. Co	unty of Death		
-	<u> </u>		Washington Cou 5. Social Security Number	inty Hospi	tal 7. Age (In yrs.	last birthdav)	Hagerst If Under 1 Year		s. 8. Date of Bi	rth Wa	shingt	on place (State or Foreign	
	Funeral Director		577-10-3702	1□M 2⊠F	92	Yrs.	Months Days	Hours Mir	n. (Month, D	ay, Year) 27, 191	I Coul	ntry) York	
II had			Usual Residence of Decedent						12000	.,,		102.1	
	rylan how		10a. State 10b. County	/	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	e Ma 3a-f s tiffied	cto	Maryland	Frederic	k	Mye	rsville					1 ☐ Yes 2 🔀 No	
	or 28	Directo	10e. Street and Number				10f. Zip Code				of What Cou	ntry?	
	s 23a	ıral	10309 Clark F		adamb Constant	0 140.1	21773		(0	USA	Race - Americ	oon Indian	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status 1X∑ Never Married 2 Ma	Armed Fo		.5.	Was Decedent of H f Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	0- 14,	Black, White,		
36	ırs afi Il", or xami	by F	3 ☐ Widowed 4 ☐ Divorce	If Yes. Giv	ve		1 □ Yes 2 □xtNo	Specify:		Sp	e <i>cify:</i> Whit	:e	
2-0036	2 hou	ted	15. Decede	nt's Education		16a. Deced	dent's Usual Occup	ation		16b. Kind	of Business/In	ndustry	
212	filed within 72 Hygiene. other than "na ent, the Medic	Completed	Elementary/Secondary (0-12)	est grade completed) College (1	1-4or 5+)	life. L	kind of work done OO NOT use retired	during most of w d)	rorking				
21	filed wil Hygien other the	9	12			Cle	rk				inting	Ī	
D	d d d	Be	17. Father's Name (First, Middle	,					ame (First, Middle		rname)		
<u>\</u>	should be and Ments marked umatic ev	은											
Maryland	ar sa		19a. Informant's Name/Relationship (Type. Print) Darlene M. Silverman/Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 10309 Clark Road, Myersville, MD 21773										
	1 and Health em 2 ther		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	1	Date	,	ion - City or To	own. State	
no	S = = 0		XX Burial 2 ☐ Cremation		State	cemetery, crer	matory or other plac Heaven Ce	1	Feb. 28,		•	ing,Marylan	
altimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Jou			i	2008			ing, hary ran	
Ra	Dep impo any	y 9	1 Dans	0			Name and Addre rancis J 00 Unive					r. MD 20901	
	T ette		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of	carsed the deat						-spr III	Annrovimate	
91	Physician	ķ.	Immediate Cause (Final disease or condition	it only one cause on e	Sc	かち	Shoc	K			- 1	Interval Between Onset and Death	
	/Medical		resulting in death)	a. Due to	(or as a conseq	ue ce of):		2.00	~1	1 -4-1		1-9	
	Examiner		Sequentially list conditions	b	d	25+11	dium Final	Diffic	1/e Co	11715		I week.	
	pi tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):	1. ` 0	Oloc	truco-	m		1	
	ecute and trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as a c nseq		may	005	11400	471	_	week	
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287	ficate phys s the	edical		.d									
Box	leath certifi attending for use as	M/n	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna		-			23d	. Date of deliv	very	
ň	death certifi e attending d for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregr	oirth 2□Feta nant at time of c		Ectopic pregnancy Other (specify)	У			Month	Day Year	
J.	t the by the	hys	9□Unknown	9□Unkn	own						_		
	The law requires that the de te has been signed by the a age 2 should be detached	ру Р	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use		the cause of death?	
g	equir sen si ould I	ted		rena	u T		4	-1/	- 1	Yes 2	No 3□Pro	bably 4 □Unknown	
ပ္ပ	law r as be 2 sh	Completed		Degu	real	mê	anny	744	24a. Wa	opsy	24b. Were auto	opsy findings available ompletion of cause of	
Y =	(G D	Sorr		Semi	le D	ene	nlego		per 1∐ Yes	formed? 2 X No	death?	2□ No	
Vital Records,	clan: ertific	Be (25. Was case referred to medic examiner?	Last and		30.	Lou		eath (Check only	one)			
	Physi this c	오	1 Yes 2 No	Hospital: 1 28a. Date		ER/Outpatier 28b. Time of		4 🗆 Nursing	Home 5 □ Res			ify)	
Division or	ding F h. After funera	ion:	27. Manner of Death 1 Natural 5 □ Pendi	/Adom	th, Day Year)	Injury	Wor	ryaτ 1k? Yes 2∐No	28d. Describe	now injury o	ccurrea		
S	Attend death ctor: y the f	icat	3 Suicide 6 Could	not be	of injury - At he	ome. farm. str	eet, factory, office	163 2 110	28f. Location	(Street and N	lumber or Rur	ral Route Number,	
2	after Direction of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of	Certification:	4 ☐ Homicide deter	mined buildi	ing, etc. (Specia	(y)	, , ,		City or To	own, State)		,	
	spita nours neral filled		29a. Certifier 17 Certify	Ing Physician: To the	e best of my kno	wledge, deat	h occurred at the ti	me, date and pla	ace, and due to the	e cause(s) an	d manner as	stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medica one)	el Examiner: On the band man	asis of examina ner stated.	ation and/or in	vestigation, in my	opinion, death oc	ccurred at the time	e, date and pla	ace, and due	to the cause(s)	
	To t To t Com	Ž	29b. Signature and title of Sertifi	er		-	29c. Licens				igned (Month		
1				4m/ L			עע	4996		Jeb	25,	2008	
	>		30. Name and address of person	n who completed caus	1		Port3/1/ L	appan	s Rd 1	Scons	5000	2008 MD21713	
	Sta Registr		31. Date filed (Month, Day, Yea, FEB 27	2008	Registrar's Signa	ature dos	de la						

State Registrar

31. Date filed (Month, Day, Year) FEB 2 7 2008

(Check only one)

29b. Signature and title of certifie



nmanica

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D66372

29d. Date signed (Month, Day, Year)

February 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:10 aM February 24 2008 Carlos Abrenilla Dela Cruz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) January 21,1943 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 M M 2 □ F Yrs Philippines 65 Director 217-31-9279 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 🛣 No a or 28a-f sh Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20904 U.S.A. 23a 2921 Gracefield Road 7 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify þ Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Retail Grocery Porter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Candido Dela Cruz Alicia Abrenilla မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an 2109 Thompson Hill Court, Silver Spring, Maryland 20905 Ruth Canubas - Daughter Department of Hee Important: If item any Inim 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial ▲ Cremation 3 Removal from State 4 Donation 5 ☐ Other 4 George Washington Cemetery 02/29/2008 Adelphi, Maryland 21. Sign Jure of Juneral ervice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Inc. Silver Spring, Maryland 20904 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between 23a. Parti. Enter the die shock, or heart feilur Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Respiratory Failure burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical Metastatic Cancer Thoracic Spine as the i The law requires that the death certificate IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed certificate 1☐ Yes 2K No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 🗓 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 24, 2008 D0050209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Brian C. Shen, 31. Date filed (Month, Day, Year) 27 2008 FEB

M.D.,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** February 23, June Lucille 2008 3:15 p.m. Bell /Medical Dyson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlotte Hall Veterans Home Charlotte Hall der 1 Year | If Under 24 Hrs. St. Mary's If Unde 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Davs Hours Min. 1 M 2 XF Yrs. Director 88 04/13/1919 054-14-5811 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Charlotte Hall 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or items any Injury or other traumatic event, the Medical Examiner must be none. 37107 New Market Road Funeral 20622 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White þ If Yes, Give Year or Dates: Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Claims Examiner U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Arthur Gordon Bell Helen M. Little 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Burch / Personal Rep. P.O. Box 286, Charlotte Hall, Maryland 20622 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 2-26-2008 | Charlotte Hall, MD 21. Signature of Funeral S 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Gause (Disease or injury Examiner The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown s been signed by the should be detach Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1□ Yes 2☑No 2∐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural within 24 hours after community the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Stephe 31. Date filed (Month, Day, Year) State MAR 0 3 2008 Registrar

30. Name and add

29b. Signature

tle of certific

person v

Cafferty,

29449 Charlotte Hall Rd., Charlotte Hall, MD 20622 M.D. egistrar's Signature

no completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

			For State	State of M						nd Mental		Em No	08	07	894
			State RegistrerAMFND#24a + 1. Decedent's Name (First, Middle		-08, HM	W,MDGE	lincate	OI D	eaui		Reg.			3. Time	of Death
	Physicia /Medic		Augustus Guian	σ						Mon Febr		Day 5, 20(Year 38	2:20	D PM M
<u>1 - </u>	Examin		4a. Facility Name (If not institution)		4b. City, To	own, or L	ocation of	Death		4c. County			
			4708 Riverdale		//	la a a fa indfa of a ch		erda		4 Hrs D Date	of Dieth			eorge	
	Funeral Director		5. Social Security Number 565-64-4716	6. Sex 7. Ag 1 💢 M 2 🗆 F	ge (in yrs.	Yrs.			Hours	Min. (Mor	of Birth oth, Day, Ye 25	ar) 1946	Cour	itry)	NES
			Usual Residence of Decedent								23,	1740			
death with the Maryland me 23a or 28e-f ehow	arylar ehow	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1		City Limits as 2 🗆 No
	h the Maryland r 28e-f ehow	Directo	MD . PRINC!	E GEORGES							100	Citizen of W	Vhat Cour		
	tter death with r Iteme 23a or			DALE RD. #1			Total Cap C		37					,	
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Decede			in? (Specify Yes	or No-	14. Race	e - Americ		
9	hours after tural', or Ite	by Fu	1 X Never Married 2 ☐ Marr	ried 1 ☐ Yes 2 🔀	No					T don't Thoung o	,				0
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ر 1	within 72 ene. than "nai	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	AUG. 25, 1946 PHILTPPIN City, Town or Location RIVERDALE 101. Zip Code 20737 DU.S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1									
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	should nd Me mark matic	2	19a. Informant's Name/Relations		LANG	19b. Mailir	ng Address (Street ar	nd Number						
Z Z	alth ar		MARK F. GUIANO	G/BROTHER		2882	SHASTA	A DR	., FA	IRFIELD	, CA.	94533	3		
o ē	ges 1 and t of Healt If Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Pamoval from State		Place of Dispo	sition (Name	of						wn, State	
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t			23a. Part1. Enter the disease, or shock, or heart failure. List					_						Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	-a Hear	Tf	ailur	ed	ue	to.	fluid	ove	Nlocy	1	Unset an	ay Death
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08/20	a × a	dlcal		d											
XOX	leath certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome								23d. Dat	e of deliv	ary	
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	iician: Th certificate rector, pag	BeC	25. Was case referred to medica examiner?						26. Place o	of Death (Check			103		
- 	Physician: this certific ral director,	은	1 Yes 2 No	Hospital:		ER/Outpatier			4 🗀 19013			e 6 ⊡Oth		'y)	
	After fune	tlon:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi		ay Year)	28b. Time of Injury	M 28	c. Injury a Work?	at ? es 2.∐N		scribe how	injury occurr	төа		
UNISION	Attending ir death. ector: After by the fune	flca	3 Suicide	not be 28e. Place of fn	jury - At h	ome, farm, str				28f. Loc	ation (Stree	t and Numb	er or Run	al Route N	umber,
5	rs after all Dire	Certification:	4 Hornicide /	building, et							or Town, S				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physicien: To the best Examiner: On the basis of and manner st	of examina	owledge, death ation and/or in	n occurred at vestigation, i	t the time n my opi	e, date and nion, death	place, and due n occurred at the	to the caus time, date	e(s) and ma and place, a	nner as s and due t	tated. o the caus	9(s)
	To the within To the comple	Me	29b. Signature and title of certifie	¥- /			29c.	License	number		29d.	Date signed	d (Month,	Day, Year)
	to -		Mula	Eloth	M	0	D	00	417	+47	2	1/2	~/	200	98
			30. Name and address of person MANIO NetCut 31. Date filed (Month Pay Year)	who completed cause of	death (Iten	п 23а) (Туре,	Print)	11	_ سے ہے۔	Ral-	- n	(H	20	1782
			31. Date filed (Month, Day, Year)	O/SOY, M/	rar's Signs	dure ture	FHO	161	23 1	DE/ CVe.	5/ 120	(41)	11501	1500/	e, MI
	Sta Registr	4000	FEB 272	nna A	K	Local	60								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician February 22, 2008 12:38 AM Melissa Ann Greer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔀 F 578-62-9309 54Yrs 1953 Mar 18, Washington, D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at Maryland Montgomery Germantown 1 □Yes 2XINo Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20876 43 Cross Laurel Court United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black. White, etc. within 72 hours after 1 □ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than "nry or other trainmatch Pharmaceutical Elementary/Secondary (0-12) College (1-4or 5+) Data Manager 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Moody Eleanor Anna Koch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Paul Greer (Husband) 43 Cross Laurel Court, Germantown, MD 20876 Baltimore, 20b. Place of Disposition (Name of Semetery, crematory or other place)
Metropolitan Pages 1 ament of He Date 20c. Location - City or Town, State February 25, 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 4 □ Donation 5 □ Other (Specify Crematory 22. Name and Address of Facility DeVol Funeral Home, Alexandria, Virginia 21. Signature of Fure ral Service Li 10 E. Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death **Physician** un Known /Medical Due to (or as a consequence of): Examiner irrhosis MKKERM Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed anaem M Kawa and Due to (or as a consequence of) physician a Vascular inheral 1) usease Physician/Medical Kelozu the attending p as IF FEMALE: Ise 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) ed by the a o 9 I Inknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 25 No has page certificate 1∏ Yes Division or Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 2 ER/Outpatient 3□ DOA 1 🗌 Yes 1 npatient P this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending Injury 1 Natural 5 Pending investigation ithin 24 hours after death.

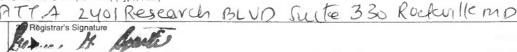
the Funeral Director: A property filled in by the further the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formula of the formu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 7 FEB 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1≈ For State Registrar	ate of Ma	aryland / De		ent of H ate of L		Mental Hy	giene Reg. No.	211118	0789	96	
4			Decedent's Name (First, Middle, Last)						2. Date of D	ath		3. Time of Dea	ath	
	Physicia		Edward 3	. Gosnel	1				Month Februar	Day y 25	Year 200		рМ	
k .	/Medic Examin		4a. Facility Name (If not institution, give street	and number)		4b. C	ty, Town, or	Location of Dea	ath	4c.	County of De	ath		
,	- LAGIIIII	dì	Anne Arundel Medical (Center			Annapo	olis			Anne	Arundel		
	Funeral		Social Security Number 6. Sex	7. Age	e (In yrs. last birtho		der 1 Year	If Under 24 Hr Hours Mir		rth	9. B	irthplace (State or Fo.	reign	
	Director		577-12 - 9065	2 🗆 F	84 Yrs	Mont.	IS Days	Hours Will	May 7,	1923		crict of Colu	umbia	
	p		Usual Residence of Decedent									Transition on the		
	ırylar thow	_	10a. State 10b. County		10c. City, Town o	r Location						10d, Inside City Li 1 ☐ Yes 2 🛣		
	e Ma Ba-f s	cto	Maryland Anne Arunde	1			Anr	napolis					7140	
	or 29	Director	10e. Street and Number			10f.	Zip Code			10g. Citi	zen of What (,		
	ath w		959 Shadewater Way					21401			U.S.A.			
	tems	Funeral	A A	as Decedent I med Forces?		I3. Was De If Yes, s	cedent of Hi specify Cuba	spanic Origin? n, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.			
20	s afte	by F	If	☑Yes 2☐N Yes, Give ear or Dates:	WWII	1 ☐ Yes	2 🗵 No	Specify:			Specify:	White		
15-0036	hour tural		15. Decedent's Education			ecedent's l	sual Occupa	ation		16b Kir	nd of Busines		-	
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7	withi iene. thar the M	E C	Elementary/Secondary (0-12) C	ollege (1-4or 5		Directo	or of Pi	ublic Wor	ks	U.S.	Naval O	al Observatory		
Ö	filled Hyg other ent, 1		17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden	Surname)			
a	ld be ental ked c	To Be								te App	pich			
\leq	shou nd M mar imati	-	19a. Informant's Name/Relationship (Type. F	rint)	19b. M	ailing Addr	ess (Street a	and Number or	Rural Route Numi	ber, City o	r Town, State	, Zip Code)		
Ĕ	nd 2 ilth a 27 is r trau		Jane E. Gosnell - Spot	ıse	95	9 Shade	ewater 1	Way, Anna	polis, Mar	yland	21401)1		
Baltimore, Maryland 2121	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. It health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of D	sposition (1	Date	-		or Town, State		
<u>و</u>	permit. Pages 1 s Department of He Important; If item any Injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	Fort Lin	-	•		29/2008	Brot	ntwood	Maryland		
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ñ	Dep Imp any onc	,	A word		ti	Hines	-Rinald: New Har	i Funeral moshire A	Home, Inc	ver Si	oring. M	aryland 2090)4	
-	4		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused	I the death. Do not							Approximate Interval Betwee		
	Dhysisian		Immediate Cause (Final	use an each iir				AH				Onset and Deat	th	
	Physician /Medical		diseas or condition resulting in death)	Due to (or as	a consequence of)	Wish	um	1/1/1/	CK			_		
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical	d											
Õ	tifica ig phr as th	ledi								T				
ROX	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	23b. was decedent pregnant	yes, outcome	pf pregnancy 2 ☐ Fetal death	3∏Ectoni	c pregnancy			1		d. Date of delivery		
	deat e atto	icia	In the past 12 months?		t time of death	5 ☐ Other					Month	Day Year	·	
J.	t the by th tache	hys	9 Unknown											
	ss the	by P	Part II. Other significant conditions contribu	ting to death b	ut not resulting in th	e underlyir	ig cause give	en in Part I.	23e. Did	tobacco u		to the cause of death		
ğ	equire en siç ould b		15then c	ACUID	on expl	- My	-		- 1	Yes 2	□ No 3□	Probably 4 Dunk	nown	
ပ္က	law re as be	plet			<u> </u>	0			24a. Wa	s an opsy	24b. Were	autopsy findings avai	ilable e of	
Vital Records,	sician: The law s certificate has b irector, page 2 s	Completed							per 1□ Yes	formed?	death	?		
<u> </u>	ian: rtifica tor, p	BeC	25. Was case referred to medical					26. Place of D	eath (Check only					
	Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2 ☐ No Hospi	al:	ent 2 ER/Outpa	atient 3	DOA Othe	er: 4 ☐ Nursing	Home 5□Res	sidence	6 □Other (S	pecify)		
0	ding Ph h. After th funeral		27. Manner of Death 28 Matural 5 ☐ Pending	la. Date of Inju (Month, Da	ıry 28b. Tin y Year) İnju		28c. Injun Worl	y at k?	28d. Describe	how injur	ry occurred			
<u>Ö</u>	Attendin death. ctor: Af y the fur	atio	2 ☐ Accident investigation			M		Yes 2 □ No						
Division or	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28	le. Place of injuding, et	ury - At home, farm c. <i>(Specify)</i>	, street, fac	tory, office		28f. Location City or To	(Street an own, State	nd Number or e)	Rural Route Number,	,	
ā	italors aft ral Di	Cer						<u> </u>						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Check only 2 Medical Examiner:	On the basis o	f examination and/									
	the Frin 24	Medical	one)	and manner sta										
	To To	2	29b. Signature and title of certifier				29c. License		2	29d. Da	te signed (Mo	onth, Day, Year)	,	
)	17/		1/1 0	0		10	MOR	105-76.	5)	tes	- 65	, 2008		
	1 "		30. Name and address of person who comple		leath (Item 23a) (Ty	0	}	B	/	1,	4	7 111	,	
				1001 P	nedica)	10	rkun) Gr	mapili	1	mo	21401	/	
	Sta		31. Date filed (Month, Day, Year) FEB 27 2008	negistr	ar's Signature	houts	, 0							
٢	Registr	ar	F E D & 1 Z000	LE MUSE.	1 10. Val									

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 4:19 P /Medical Cyrus Gambrill Jr March 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Apr. 29, 7. Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** 1XM 2□ F Maryland 219-14-9547 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ns 23a or 28a-f shov must be notified at Frederick 1 **∑**es 2 □ No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Record Street 21701 U.S.A. ould be filed within 72 hours after death Mental Hygiene. Funeral ral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Mircowave Engineer Physics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyrus Gambrill, Sr. Miriam Hagedorn ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan G. Tremaine, daughter 16147 Eyler's Valley Road, Thurmont, MD 21788-1026 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery Mar. 10, 2008 Frederick, MD 4 Donation 5 Dother (Specify) ^{22. N}Keeney and assford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service No Insee MO0255 his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer /Medical Due to (or as a consult ence of): Examiner oneumonio Sequentially list conditions, if any lacking to in a single cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No e Hospital or Attendi 24 hours after death, e Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D003516 3/6/2008 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

Myung Nam, M.D., 400 West 7th Street, Frederick, MD 21701

Registrar

31. Date filed (Month, Day, Year) MAR 1 2 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 7:25 PM MARY ALICE GRAY BOOL /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLATA CIVISTA MEDICAI CENTER HARLES Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1 ☐ M 2 ☐ F 93 Director 579-34-6019 MARYLAND JULY 10,1914 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2K No notified Director MD. CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 must be n 4140 OLD WASHINGTON RD. 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any Injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 1 Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET GENEVA RIDGEWAY RICHARD OLLIE DeVAUGHN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 BANBURY CR. SIMPSONVILLE, S.C. 29681 DIANE McDONALD-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) CHARLES MEM.GARDENS 3-10-08 LEONARDTOWN, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. M00479 LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Canzasti if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has le 2 page certificate 1∐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this (P funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 ☐ Pending investigation Year) 1 Natural 2 Accident (Month, Day Injury within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of contified 0061652 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 101 Waldock Post Office ATUL KATYM 6 31. Date filed (Month, Day, Year) 32. Resstrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAR 12

MARY

			For State Registrar	State of Maryl		epartment of H Certificate of L			ene g. No. 20 (08	07899
W	Dhi.i.i		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month		ear	3. Time of Death
	Physicia /Medic		Catherine Pollard	Hart				February	- i		4:30a [™]
,	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of I	Death	
<u> </u>	eric	-	Windmill Sq. II 18					T = = = = = = = = = = = = = = = = = = =	Prince		
1,426,	Funeral Director		225-32-9105	7. Age (In	yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/23/1	Year) 9. 920 V	Birthpla Countr irgi	ace (State or Foreign y) Lnia
	and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town o	r Location				10	d. Inside City Limits
	Maryl f sho fed a	lo	Maryland Prince G	eorge's M	itchel	lville					1 ☐XYes 2 ☐ No
	28a-	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Countr	ry?
	3a or		4003 Clairton Dri	170		20721	I		USA		
	deatl ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S.	13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race -		
2-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1		1 ☐ Yes 2½ No		nican, etc.)	Specify:	White, et	Black
Ş	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. De	ecedent's Usual Occupa	ation	ing 1	6b. Kind of Busin	ess/Indu	ıstry
7	within 72 ene. than "na'	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	- 'ii	Rive kind of work done of fe. DO NOT use retired	l)	ing			
7	filed wi Hygien other th	S	12			Homemaker			Priv	ate	
yland	ild be fill lental H ked oth ic even	Be	17. Father's Name (First, Middle, Last)	1				e (First, Middle, M	aiden Surname)		
<u>Ş</u>	ould be Menta narked natic ev	P	John Daniel Polls					Fleming			
, Mar	es 1 and 2 should to of Health and Ment item 27 is marked rother traumatice		19a. Informant's Name/Relationship (7. Catherine Hart (D.	aughter)	Win	dailing Address (Street a	II 1826 D	utch Vil	lage Dri	ve,	Landover85
ore	Pages 1 nent of H ant: If iter any or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	-	isposition (Name of crematory or other plac	i		0c. Location - Cit	y or Tow	n, State
	nit. Pag artmen ortant: Injury (4 ☐ Donation 5 ☐ Other (Specify) 1	Fort Li	ncoln Ceme			rentwood		
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service Licent	Ville		22. Name and Address 3401 Blade					ome 0722
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cone cause on each line.	death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arre	st,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 01	VACION	Caucez					Onset and Death
1	/Medical		resulting in death)	Due to (or as a cor	sequence of):						
	Examiner	_	Sequentially list conditions,	b							
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury	Due to (or as a cor	isequence of):					4	
_	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cor	sequence of):					+	
2	be egician ician buria										
08/00	ficate phys s the	edical		d						+	
ROX	ath cert attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100	23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date o		y Day Year
9	t the carrier	hysi	9 Unknown	9□Unknown				_			
ī,	w requires that the de t een signed by the s should be detached	by P	Part II. Other significant conditions of	ontributing to death but not	resulting in th	e underlying cause give	en in Part I.	23e. Did toba	acco use contribu	ite to the	cause of death?
ğ	quire en sig uld b)rabeles	type 2				1 ☐ Yes	s 2 No 3	Proba	bly 4 □Unknown
Records,	faw re as t ee 2 sho	Completed	_	· V				24a. Was an			sy findings available
	و ع و	Eo						autopsy perform 1 Yes 2	ed? dea	th?	pletion of cause of
VITAI	sician: h certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one			
	hyslcian: nis certific director,	20	1 Yes 2 10	Hospital: 1 ☐ Inpatient	2 ER/Outpa	tient 3 DOA Othe	er: 4 Nursing Ho	ome 5 🗆 Resider	nce 6 KlOther	(Specify)	Daughter's Home
ō =	Attending Physician: r death. ector: After this certific by the funeral director,	:uc	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Tim ar) lnju		y at k?	28d. Describe how	w injury occurred		
20	eath. or: A	satic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No				
UIVISION	or Attendater death	ertification:	4 Homicide determined	28e. Place of injury - building, etc. (Sp	At home, farm pecify)	, street, factory, office		28f. Location (Str. City or Town,	eet and Number (State)	or Rural	Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	O	29a, Certifier 1 Certifying Phy	/sician: To the best of my	knowledge. d	eath occurred at the tin	ne, date and place.	and due to the ca	use(s) and mann	er as sta	ated
	e Hos 124 h e Fur letely	edical		iner: On the basis of examiner stated.							
	To th Withir To th Comp	Me	29b. Signature and title of certifier	1 / 1 .		29c. License	e number	29	d. Date signed (/		Day, Year)
)				uu .		D	0061.70	4	2/2	6/8	
1	2 (10)		30. Name and address of person who of	completed cause of death	(Item 23a) (Ty	pe, Print)	MD 20	708		•	
P	Sta	te	31. Date filed (Month, Day, Year) FFB 2 8 2008	32. Registrar's S	ionature .		//				
	Registr	ar	LERY O SONO	en XX p	MAL!						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. Day 2008 ear **Physician** 21, 9:48P R. HAWKINS **HELENA** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Aug. 6, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F Maryland 214-32-9573 83 Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits XXes 2 □ No Director Gaithersburg MD Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9350 Brink Road 20882 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🔼 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) 12th College (1-4or 5+) Teacher's Aide Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Prather Tonia Rubin Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9350 Brink Rd Gaithersburg, MD 20882 19a. Informant's Name/Relationship (Type. Print) James W. Hawkins-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Surial 2 □ Cremation 3 □ Removal from State Parklawn Mem Park 2/27/08 Rockville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, 21. Signature of Funeral Service Licensee 246 N. Washington St Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the dise v., or complications that caused the death. shock, or heart fall v... List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hypertension 1 Yes 2 No 3 Probably 4 Vunknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No 24a Was an certificate has b lirector, page 2 s 2€ No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo Certification: To 1 Inpatient 2X ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending Injury in 24 hours arren war de Euneral Director: Afrancely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 296. Signature and title of certifier 02-72-2008 m 10 O Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 ^{Year)} 27 gistrar's Signature 31. Date filed (Month, Day, State FEB 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 **Physician** March 6, 0230 Max Everett Hutsell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. Director July 27,1939 Tennessee 414-60-0569 68 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Yes 2 No Directo MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 635 Sadler St. Completed by Funeral 21001 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: The Medical Exar White 3 ₩ Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Computers U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be ind Mental William Hutsell Willie Mae Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland Max Hutsell (Son) 1211 Light St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition ō Department of important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/12/08 Owings Mills, MD Garrison Forest Vet. Cem. 21. Signature Funeral en la Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 rance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Comac Cance **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificete has l irector, page 2 s 2□ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Thomicide

State

To the

Hutsell,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 000 63220

29d. Date signed (Month, Day, Year) 8005

GEORGE R. BEL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 MPPER CHESAPEAKE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

MAR 12 2008



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 10MC15 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSDITOL KIVES (Onty Security Number 24485 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 9. Birthplac (State or Foreign **Funeral** Director Usual Residence of Decedent death with the Maryland State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1948 -1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2NNo Specify. ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during a life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vans porta Father's Name (First, Middle, Last) ther's Name (First, Middle Majden Surname aven co 19a Informant's Name Relationship (Type. 19b. Mailing Address (Street and Number or Ryral Route Number, City State Place of Disposition (Name cemetery, crematory or other 20c. Location - City or Town 20a. Method of Disposition 3 ☐ Removal from State 1 Burial 2 Cremation Feb 22,08 4 □ Po ation 5 ☐ Othe (Specify) 22. Name and Address of Facility Con60 Funeval 21. Signatu e of Funeral Service alised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ach line. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATTIONOS CLUROTIC CARDIOVASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ HYPERLIPID EMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XYes 2 No 2 R/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DON'TY MORNEAL 02/14/2008 00057509 OXPAINER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JAMES LACE, MO

FEB 2 6

31. Date filed (Month, Day, Year)

Tex 122

32. Registrar's Signature

2008 07903

hael Jayvon		es State of Maryland / Department of H 1- For State Certificate of D	eaim and Mentarriy eath		200	0 0100
		Registrar 1. Decedent's Name (First, Middle,Last)	- I	Reg. No. 2. Date of Death		3. Time of Death
Physicia dical Exami	in/ ner	Raphael Jayvon Jones		Month Day February 23, 20		2127 hrs
Licai Lxaiiii	i.c.i	4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	40	c. County of Death	
		Pennsylvania Avenue & Spaulding Avenue	Capitol Heights		Prince George	
Funeral		5. Social Security Number 10. Sex	f Under 1 Year If Under 24Hrs Months Days Hours Min		Foreig	n Wasii.
Director		579198265 1XM 2 F 17 Yrs.	VIOLITIS Days 110013 IVIII.	12/22/	1990 Co	D.C.
		Usual Residence of Decedent				10d. Inside City Limits
v any		10a. State 10b. County 10c. City, Town or Location	m			1 X Yes 2 No
and f shov	ō	D.C. Washingto	Of, Zip Code	10g. Ci	tizen of What Cou	ntry?
Maryl 28a-	Director	10e. Street and Number			ted Sta	
h the	Ö	320 16th Street S.E.	20003 Decedent of Hispanic Origin? (S			ican Indian, Black,
th wit ems 2	Funeral	1 X Never Married 2 Married Armed Forces? If Yes,	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
er dea	Ē	1 Yes Za No	es 2x No specify:		Specify: Bla	ck
11215-0036 It be filed within 72 hours after death with the Maryland Aental Hygiene. Amarked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	l by	or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's	Usual Occupation (Give kind of of working life. DO NOT use ref		. Kind of Business	Industry
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				boo!
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D 2 should mid M r is m	ြင		ochelle Ave.	, #1726 F	orestvi	lle Md.
mnd 2:		20a, Method of Disposition 20b. Place of Disposition	on (Name of cemetery,	Date 20	c. Location - City o	r Town, State
Ore ges 1 a t of H t of H		1 Removal from State crematory or other Specify:	1	1/2008 Br	entwood	d, Maryland
ti. Pay		22. Na	me and Address of FacilityPot	oe Funera	1 Homes	s, P.A.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Sel shull hand Montal Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ance.		Aut are MILLE 155	88 Marlboro	Pike Fore	stville	e, Ma. 20/
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate interval Between Onset and
» IMedica		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Death
amine		or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, Life any leading to immediate b. Due to (or as a consequence of):				
	odical Examiner	if any, leading to immediate cause. Enter Underlying Cause cause. Enter Underlying Cause C.				
T	5	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
30x 68760, death certificate be executed the attending physician and of for use as the burial - transit	1 4	dd				
O, e be ex ysician burial	1	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
68761 certificate nding phy	3		al death 3 Ectopic preg	nancy	Month	Day Year
x 68 th cert tendir	M/acioia	past 12 months? 4 Pregnant at time of death 5 Oth	er (Specify)			
m ÷ ≗ −	<u> </u>	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
, P.O. rres that the signed by	2 74	Part II. Other significant conditions contributing to death but not resulting in the ur	, 5	1 Yes	2 🗸 No 3 🗌 P	robably 4 Unknown
S, F puires en sign				24a. Was an	24b. Were	autopsy findings available to completion of cause of
cords, law requir	9			autopsy performe	ed? death	?
ial Records, ian: The law requir certificate has been s	, page 2 should be		26.Place of Death (Che	1 Yes 2	No 1 🗸	163 2 110
Vital hysician:	5 6	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	Other:		sidence 6 🗸 O	her: Scene
f Vi Physi er this	5 F	1 Yes 2 No 27 Manner of Death 28a, Date of Injury 28b. Time of Ir		28d. Describe how Occupant of a	v injury occurred	ad objects
n of ading Pl	e runeral	1 Natural 5 Pending Feb 23, 2008 2106 hrs	1 Yes 2 ✔ No	l '		
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Division of Vital Records, P.O. It to the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	completely filled in by the	determined (Specify) Local Street		NB Penn Avenu	e @ Alton St., C	Capitol Heights, MD
Hospi 24 hou Fune			red at the time, date and place,	and due to the cause(s) and manner as:	stated. o the cause(s)
To the within To the	emple:	29b. Signature and title of certifier Cybeck only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.		ed at the time, date an	29d. Date signed	(Month, Day, Year)
F 3 F	۶ :	29b. Signature and title of certifier	29c. License number		February 24,	
		m m , m 7	O.C.M.E.			
0 (0)		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street	et Baltimore MD 21201			
KO/		32 Registrar's Signature	st, Dalambio, MD 21201			
Reg	Sta iistr	16 ST. Balleting O. S. 2008				
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			for State Registrar MEND#10bperF	State of Maryland	-	artment of H		Mental Hy	giene Reg. No.	200	8 07904
			Decedent's Name (First, Middle, L.)					2. Date of De		Year	3. Time of Death
	Physicia /Medic		Esther	Joffe				Febru	ary 2	4, 200	
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or		ath		County of Deat	
	Side V		3122 Gracefield 5. Social Security Number 6.	Road Apt 514 Sex 7. Age (In yrs. la	ast hirthday)	Silver S		s. 8. Date of Bi	rth	ntgome:	ry hplace (State or Foreign
	Funeral Director		578-01-2759	1□ M 2X F 90	Yrs.	Months Days	Hours Mir		ay, Year)	Co	timore, MD
			Usual Residence of Decedent		T			10/10		7,50-2	
	anylar show	'n		regalicity	Town or Lo ver St						10d. Inside City Limits 1 X Yes 2 No
	the M	Funeral Director	10e. Street and Number	Georges	.VCI D	10f. Zip Code			10a Citiza	en of What Co	
	aa or t be r	I Dil	3122 Gracefield I	Road Ant 51/		20904				ted St	-
	death ms 2: r mus	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H		(Specify Yes or N		4. Race - Ame	rican Indian,
0	after or ite	/ Fu	1 ☐ Never Married 2 【X Married			ires, specify cube 1 □ Yes 2 ဩ(No	Specify:	ono moan, etc.)		Black, Whit Specify:	White
	hours ural",	d by	3 Widowed 4 Divorced	Year or Dates:							
2	in 72 i "nat ledica	olete	15. Decedent's (Specify only highest of	rade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of w f)	rorking	TOD. KIII	d of Business/	industry
7 7	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Acc	ountant			R	etail	
2	e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Na	ame (First, Middle	e, Maiden S	Surname)	
N N	Ment Ment arked aric e	To E	David Striner		1			Magazine			
Mar	12 sho		19a. Informant's Name/Relationship Mark Joffe - So		1	ig Address <i>(Street)</i> Green Pas					
ָ ט	1 and Health em 27		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of		Date		ation - City or	
<u> </u>	ages ent of it: If It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State Kin	emetery, crer 1g Day:	matory or other plac id Memori rdens	al 2	/26/08	 Fa11	s Chur	ch. VA
allillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lie		22	2. Name and Addre	ss of Facility				
Ď	permi Depar Impor any ir	10 1			1	dward Sag	etie Pi	ke Rockv	illen	MD 208.	52
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death ly one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Congestive	Hear	t Failure	!				5 Years
۱	/Medical Examiner		resulting in death)	Due to (or as a consequ							5 Years
		ē	Sequentially list conditions,	b. Pulmonary		tension					J lears
	uted d ansit	Examin	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Š	an an	Еха	resulting in death) Last	c Due to (or as a consequ	ence of):						
0100,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d							
Š	w requires that the death certific. been signed by the attending pl should be detached for use as t		IF FEMALE:	23c. If yes, outcome pf pregnar	ncv					3d. Date of de	
DOX	eath atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3[Ectopic pregnancy Other (specify)	/		2.	Month	Day Year
	the d	Physician/Me	1 ☐ Yes 2 ☐ Who 9 ☐ Unknown	9□Unknown							
Ų.	s that jned b	by PI	Part II. Other significant conditions	contributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Spics	en sig							_ 1 🗆	Yes 2X]No 3 P	robably 4 ☐Unknown
ว	law rias be	Completed						24a. Wa:	opsy	prior to	utopsy findings available completion of cause of
₩ ₩	: The cate ha	Con						per 1□ Yes	formed? 2 X No	death? 1 ☐ Yes	2 X No
N II A	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	- n /Ott	ot 3 DOA Oth		eath (Check only			
5	Physer this eral di	1. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ E	28b. Time o	IL OLI DOX	4 Linursing	Home 5 Res			ecify)
5	ath. r: Afte	atior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury		K? Yes 2 □ No				
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5	ital o irs aft ral Di			<u> </u>				<u> </u>			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2	edical		Physician: To the best of my know aminer: On the basis of examinat and manner stated.							
	o the	Mec	29b. Signature and title of certification		9	29c. Licens	e number		29d. Date	e signed (Mon	th, Day, Year)
)	- 5 - 0		> /lller	llecestra	0	D240	93		Feb	ruary	25, 2008
0	10		30. Name and address of person wh	no completed cause of death (Item	23a) (Type,	Print)					
			Mark Parkhurst M			d Silver	Spring	MD 20904			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7	32 Registrar's Signat		well !					
	nogisti		I ED H . C	LEGISLA LA	A STATE						

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State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kloesz

MAR 1 2

6701

32. Registrar's Signature

ORIGINAL

14 Charles

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21204

			Pleas	e Type or Prir							-	
			For State	State of Ma	arylan		artment of F rtificate of		d Mental F	- 0	000	0 7006
			Registrar 1. Decedent's Name (First, Middle,	Last)			Tillicale of	Dealli	2. Date of		Bus W W	3. Time of Death
	sici: ledic	_	Kan	ren Louise	Jarbo	e			Marcl	1 5, D	2008 Yea	9:44 A M
	amin	NO.	4a. Facility Name (If not institution,		1		4b. City, Town, o		ath		County of De	
			44249-1 Clarkes 5. Social Security Number			last birthday)	Hollywo If Under 1 Year			Birth	St. Mar	y 'S irthplace (State or Foreign
Fune Direc			214-54-0870	1□M 21X F	62	Yrs.	Months Days	Hours M		Day, Year Der 30	10/5	country) st Virginia
and			Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
Maryl	педа	tor	Maryland S	St. Mary's			Но	11ywood				1 □ Yes 2本 No
ith the	or ac	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What (-
eath w	DON	eral	44249-1 Clarkes	Landing Roa		S 12		636	(Specify Vac or	No	USA	nerican Indian,
after d	niner	Fun	1 ☐ Never Married 2K Marrie	Armed Forces?		- 1	Was Decedent of H		erto Rican, etc.)	140-	Black, Wh	nite, etc.
5-UU30 72 hours after death with the Maryland Inatural", or items 23a or 28a-f show	Exa	d by	3 Widowed 4 Divorced	Year or Dates:			1 ☐ Yes 21 No				Specify: W	
in 72 t	edica	olete	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation <i>during m</i> ost of v d)	vorking		Kind of Busines	
d withir giene.	me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		naker				wn Home	
d be file	event	Be	17. Father's Name (First, Middle, La	ast)					lame <i>(First, Mid</i> Margare			
hould Mer marke	manc	ဍ	Edward Grey 19a. Informant's Name/Relationship	(Type, Print)		19h Maili	ng Address (Street					Zin Code)
INIG 2 salth ar 27 ls	a man		Michael Jarboe									, MD 20636
Dalumore, Maryland 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "instural" or items 23a or 28a-f show in the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the con	or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3	B □ Removal from State	C	emetery, cre	osition (Name of matory or other pla		Date rch 11,		ocation - City o	
Dallillor	dini		4 □ Donation 5 □ Other (Spe	ecify)	Char		norial Gard	ens 20	008			Maryland
Depa Dermi	once.	i	21. Signature of Funeral Service Li	Jardine	2		P.O. Box 2 Leonardtown	/0		-Gardi	.ner Fune	ral Home, P.A.
	3		23a. Part1 Enter the disease, or c shock, or heart failure. List of	omplications that caused nly one cause on each li	I the death ne.	n. Do not en	ter the mode of dyii	•	•			Approximate Interval Between Onset and Death
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Examir				Brei	a consequ	A Trun	25.25			C2	nat	
p _e *	110	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):	•					
execute and	al-11811	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):						
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ertificate ing phys	200	Physician/Medical	IF FEMALE:	202				7.70%				
eath cer attendin	Sn ZO	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth 4 ☐Pregnant at	2 Feta	death 3	☐Ectopic pregnanc	у			23d. Date of d Month	elivery Day Year
t the d	30160	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown								
The law requires that the death certificate be executed the has been signed by the attending physician and sone 2 should be detached for use of the buriet transit	an an	þ	Part II. Other significant condition	s contributing to death b	ut not resu	ılting in the u	inderlying cause giv	ren in Part I.				to the cause of death? Probably 4 Unknown
law requires t	inolis inolis	Completed							24a. W			autopsy findings available
Physician: The law in this certificate has be read director, page 2 at 1	rage z	шо							– a p 1⊟ Ye	utopsy erformed? s 272N	prior to death?	completion of cause of
clan: T	Sciol,	BeC	25. Was case referred to medical examiner?						Death (Check on			
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nding th.		tion	Natural 5 Pending investiga	(Month, Da	y Year)	Injury	Wor	k? Yes 2∐No	Zod. Descri	oc now inje	ary occurred	
or Atter	iii Dy tii	Certification:	3 Suicide 6 Could no 4 Homicide determin				reet, factory, office		28f. Locatio City or	n <i>(Street</i> a Town, Stat	nd Number or i	Rural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, again	reily illed		29a. Certifier Check only one) Certifying 2 Medicai Ex	Physician: To the best caminer: On the basis o	f examinat	wledge, deat tion and/or ir	th occurred at the ti	me, date and pla	ace, and due to ccurred at the tir	the cause(s	s) and manner and place, and d	as stated. ue to the cause(s)
Fo the vithin 2 Fo the	Did in	Medical	29b. Signatule and title of certifier	and manner sta	ated.		29c. Licens	e number		29d. Da	ate signed (Mo	nth, Day, Year)
1			> hh	8			DO	0622	88	3	1510	8
OB			30. Name and address of person w	no completed cause of d		23a) (Type,	Print) In rep 1	ntch p	d # IK	0-	l'Anni	mo 2068
6	Sta		31. Date filed (Month, Day, Year)	32. Pegistra	- Dr		THE COR	NICHE	a out	UQ	WISCTIA	1100 2061)
Reç	gistra	ar	MAR 0 7	ZUUč	and p		marke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** A^{M} Teresa Lynn Jensen March 2008 4:51 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Ye Apr. 15 9. Birthplace (State or Foreign Country)
9 MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Year) Davs Months Hours 1 □ M 2 🛣 1959 48 Apr. Director 217-76-5281 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 X No Director MD Frederick Jefferson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If flem 27 is marked other than "natural", or items 23a or 2, any Injury or other traumatic event, the Medical Examiner moderne. 21755 USA 5104 Old Middletown Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12)College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Eugene Kline Ineze McIntyre ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21755 19a. Informant's Name/Relationship (Type. Print) Crystal Brandenburg (Daugter)5104 Old Middletown Rd., Jefferson, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Cemetery 3/8/08 Myersville, MD Schatur of Funeral % Donald B. Thompson Funeral Home Licensee P. O. Box 18, Middletown, MD 21769 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or comshock, or heart failure. List only imme liale Cause (Final **Physician** 1-way1c disease or condition resulting in death) /Medical Due to (or as a consequence of): Keepston. Examiner Sequentially list conditions, it is conditionally cause. Enter Underlying Cause (Disease or injury that is it is the cause or injury that is it is in the cause or injury that is it is in the cause or injury that is it is in the cause or injury that is in the cause or injury that is in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cau Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2□ No 1 Yes 2 WNo Hospital or Attending Physician: director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury 27. Manner death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Reference of the filled in by the filled in by the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in th 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 1 2 2008

Raza

, Kaza

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



within 24 ho

To the Function

completely f

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Hornberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 Forest Hill, Md. 20c. Location - City or Town, State Air Mem. Gardens 3/7/2008 Bel Air, Maryland 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. Approximate Interval Between Onset and Death 23d Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29c. License number 29d. Date signed (Month, Day, Year) 032255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ~ 615 W. MacPhail Rd. Suite 106 Bel Air, MD 21014 32 Registrar's Signature **ORIGINAL**

2. Date of Death

Day 2008

4c. County of Death

Harford

14. Race - American Indian Black, White, etc.

Home

White

Specify:

4:30 A M

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

1 ☐ Yes 2 X No

State Registrar

DHMH 17 Rev 1/2001

Diwel 5 De

2008

DAVIDS DU

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** Year THI LANH FEB. 23, 2008 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 27 F Yrs. Director 218-94-4253 75 SEPT. 16,1932 VIETNAM Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1505 HAMPSHIRE WEST CT. #5 20903 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Completed by 3 Widowed 4 □ Divorced Specify: ASIAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER HOME Pages 1 and 2 should be filed nent of Health and Mental Hygi nt: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VINH ဥ PHUONG LY XAU THTHO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIM CICELE LAY/DAUGHTER S.E. 34th AVE., BOYTON BEACH, FL. 33435 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If |
any Injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 2-27-2008 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. e that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieute of Injury) that initiated events resulting in death) Last Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed: certificate 2 UN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

Division or Vital Records, P.O. Box 68760

the Hospital or Attending Physician: within 24 hours and To the Funeral Dir

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Gentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) Registrar's Signature FEB 2008

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#5perINF3/4/08, EMW, MbCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:08 A^M 23, 2008 February Frances Timberlake Lillis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 227-64-9433 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🛣 F June 18, 1950 India Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r 28a-f show notified at 1XYes 2 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number pe a United States 20852 809 Leverton Road "natural", or items 23a edical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. 3altimore, Maryland 21215-0036 Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Education Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Meehan Clare H. Timberlake 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 an.
Department of Health
Important: If item 27
any injury or other tra 809 Leverton Road Rockville, MD 20852 J. Patrick Lillis (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Feb. 28 1X Burial 2 □ Cremation 3 ☐Removal from State 2008 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Servi 10 East Deer Park Drive Gaithersburg, MD 20877 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one car e on each line. Approximate Interval Between Onset and Death Part1. Ent ir the disc as shock, or leart failure. lumodiate use (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): RANCES LES LES. OCOS LES. or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Metastatic Glioblastoma Multiforme 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 sl autopsy performed? Yes 2 No LIS, FRANC 23.08 cd Division or Vital B 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2No 1X Inpatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending investigation n 24 hours are, the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 定 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifier D66300 February 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sujay Tagore M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 27 FEB 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** William | Paris Lee February 25, 2008 11:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs Director 577-07-3998 90 March 28,1917 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☐ No Directo **Hughesville** Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20637 USA 5990 Swanson Creek Lane Funeral Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: White 1 ☐ Yes 2017 No Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager/Buyer Retail Carpet 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert E. Lee Margaret Simpson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5990 Swanson Creek La., Hughesville, MD 20637 Candace Oberti/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/4/2008 Suitland, MD Cedar Hill 22 Name and Address of Fac 21. Signature of Funeral Service Literal Brinsfield-Echols Funeral HOme, P.A. M00817 30195 Three Notch Rd/, Charlotte Hall,MD20622 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 yrs Physician Alzheimers Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? res 2/2/No 1□ Yes Chronic Kidney Disease Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 D Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the To the Hospital o within 24 hours aff To the Funeral Di

Baltimore, Maryland 21215-0036

31. Date filed (Maria Ry, 0ea 3 2008 State Registrar

29b. Signature and titte of certifier

29a. Certifier

(Check only one)

Medical

ł5092

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

S. JANI

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Covering MD - PARUL Dr. Louis Kaufman PARUL S. JANICharlotte Hall, Maryland 20622

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 29 **Physician** 11:30 PM February 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number Examine Ma alumbia yland General Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 M XX 94 Ohio Director June15,1913 271-05-6909 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show at 1 ☐ Yes 2X No "natural", or items 23a or 28a-f shedical Examiner must be notified Director Maryland Howard Ellicott City 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 21043 U.S.A. 3004 North Ridge Road #314 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White Specify: ş 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) the Homemaker Own Home Ith and Mental Hygier 27 Is marked other the r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Frances Nowecka Paul Recko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 3113 The Oaks Road, Ellicott City, Maryland 19a, Informant's Name/Relationship (Type, Print) of Health Department of Health Important: If item 27 any injury or other trong once. 27 Kenneth Loje Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 3-6-08 Northfield, Ohio 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A 6009Harford Road, Baltimore, Maryland21214 michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart failure onaestive year **Physician** /Medical Due to (or as onsequence of) Examiner Sequentially list conditions, if any load of the cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Month Vear in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Physiclan: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a Date of Injury 28h Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar

DHMH 17 Rev 1/2001

State

Registrar

Albert

2008

31. Date filed (Month, Day, Year) MAR 1 2 20

32. Registrar's Signature

completed cause of death (Hern 23a) (Type, Print) Charter Drive, Srite 200 Columbia, MD

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 "natural", or is marked other item 27 i

Physician

/Medical

Examiner

Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 7, 1937 9. Birthplace (State or Foreign 5. Social Securify Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours MXM 2∏F Washington, DC 71 **Director** 579-46-1394 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12361 Silver Rock Circle 20657 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★IYes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Photographer/Map Maker Dept. of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Edna Dement Wellington Long မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen N. Long/Spouse 12361 Silver Rock Cr., Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 3/6/2008 Brinsfield-Echols Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Brinsfield-Echols Funeral Home, P.A 30195 Three Notch Rd., Charlotte Ha MD 20622 Charlotte Hall, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Irjury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months? Day Year 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yés 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ★ 1 1 | 2 ER/Outpatient 3 DOA ို 27. Manner of Teath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation (Month, Day Year) Injury 1 Natural within 24 hours and control To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) 0) Joseph J. Barth Prince Frederick, MD egistrar's Signature State Registrar

08-01332	
Marie Louis	

arie Louis		State of Maryland / Department of For State State of Maryland / Department of For State Certificate of E		giene Reg. N	lo. 20	08 0791
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exami	ner	Marie Louis		Month Da February 15,		2323 hrs
		Tall Commy (Control Control Co	. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director		o. Social Security Notified	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (M	M/DD/YYYY) 9. Bir Foreig	thplace (State or gn puntry) Haiti
	-	769-03-3806 1 M 2XF 41 Yrs. Usual Residence of Decedent		Joury25	, 12001	
aux		10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
<u> </u>	_	Maryland Howard Columbia				1 Y Yes 2 No
faryland 28a-f show 1 at once.	탏	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
the N	ä	9430 Merryrest Road	21045		iti	
72 hours after death with the Maryland nu "natural", or items 23a or 28a-f sho		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Sps, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	rican Indian, Black,
death or ites	Ĕ	1 X Never Married 2 Married 1 Yes 2 X No			Specify: Bla	o a k
after ral",	à	or Dates:	Yes 2 No specify: s Usual Occupation (Give kind of w	ork done 16	b. Kind of Business	
hours after "natural", Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use retir			
36 nin 72 s. than '	plet	12 Coo	ok		Hotel	
15-0036 filed within 72 al Hygiene. ed other than t, the Medical	Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Maio	den Surname)	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than '	Be	Bonifaphase Louis	Marie G	erome		
	P	1	Address (Street and Number or F			
MD ;			-E 110Terrace	Miami,	Florida Oc. Location - City o	3 3 1 6 1 r Town, State
4. if the graph in		A Vanish of Commettee 3 Removal from State crematory or other	er place)			
Page ment tant: or otl		4 Donation 5 Other Specify: SouthernM	MemorialPark	3-1-08 [1	.Miami	Beach, FL.
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Na	ame and Address of Facility	rzullo	Funeral	Chapel, P. A
		21. Signature of Funeral Service Licensee Muchael Party 1. Enter the disease, or complications that caused the death. Do not enter the failure List only one cause on each line.	0.9 Hartord Ro e mode of dying, such as cardiac of	r respiratory arrest	imore, Ma , shock, or heart	T American de la constanta
Physician Medical	16 16	Alaskal interviention and d				Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Howing			
		Sequentially list conditions, b				
	iner	if any, leading to immediate cause. Enter Underlying Cause				63
	am	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
be executed ician and urial - transit	dical Examiner	d				
), be exe ician a		XUNPENDED AMENDED 7,28a-f, perME,g87	7 3/12/08 TT		Don Britani della	
ox 68760, eath certificate b attending physic for use as the bu	sician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fet	tal death 3 Ectopic pregn	ancy	23d. Date of delive Month	Day Year
c 68 c certif ending use as	ciar	past 12 months?	ner (Specify)			
Division of Vital Records, P.O. Box 68760 rat or Attending Physician: The law requires that the death certificate by an in Director: After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the by	Physi	1 Yes 2 No 9 V Unknown g Unknown		Las Billi		to the cause of death?
D.O. B that the d ned by the detached	by PI	Part II. Other significant conditions contributing to death but not resulting in the un	inderlying cause given in Part I.			robably 4 Unknown
cords, P.C. Haw requires that that been signed lee 2 should be deta	pa p			24a. Was an		autopsy findings available
ord: w requisible been should	plet			autopsy perform	prior t	o completion of cause of
Reco	Completed			1 ✓ Yes 2		Yes 2 No
Vital Rec nystelan; The this certificate	Be C	25. Was case referred to medical examiner? Hospital: Invasion 2 PC ER/Outpatient	26.Place of Death (Check		esidence 6 Otl	ner:
'Yithis al dire	2	1 ✓ Yes 2 No 1 Inpatient 2 ✓ ER/Outpatient			w injury occurred	101.
ing Pl	ü	(Month, Day, Year)	A Ven a V No			and drowned
VISION or Attendather death Director:	cati	Pending Investigation FNd 2/15/2008 Fnd 1:0	O pin	_		Rural Route Number, City
Division / all or / safter all Direct ed in t	Certification:	Suicide 6 Could not be determined (Specify) Bathtub	o,, , , , , , , , , , , , , , , , , , ,			pt A Columbia, 1
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by	ဦ	29a. Certifier , The best of my knowledge, death occur	rred at the time, date and place, ar	d due to the cause	(s) and manner as s	tated.
the H thin 24 the F	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigate	tion, in my opinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
To To	Ne.	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (i	Month, Day, Year)
		Warrante M. Wall	O.C.M.E.		February 16, 2	008
		30. Name and address of person who completed cause of death (Item 23a)				
		Margarita Korell MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, MD	21201		
	tate	31. Date filed (Month, Day, Year) 37. Registrar's Signature	BI			
Regi	strar	7				
DHMH 17 Rev 1/	2001	ORIGINA	NL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Amended item#73/3/08, SLU, WCHI Certificate of Death Reg. No.-3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 07 Raymond Leonard, Sr. ೨ಎ 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** Wicomic adis bur Hospice at The If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Hours 1₩ M 2□ F Months Days 220-28-4367 72 Director 1935 MD Usual Residence of Decedent 1934 Mar 15, 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 √Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Swan Road 21801 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Laborer Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Corby Leonard Gertrude Showell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Swan Rd., Salisbury, MD 21801 Mary C. Leonard/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park | 03/01/2008 Salisbury, MD 22. Name and Address of Facility
Lewis N. Watson Funeral Home 21. Signature of Funeral Service Licens 1618 West Rd., Salisbury, MD 21801 23a 1. Enter the disease, or conflictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur, a strong on cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) PARKINSON DESEASE **Physician** /Medical Due to (or as a consequence of): Examiner BUMONIAS ASPIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate | 2 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No 1#1npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20058410

State Registrar 6 Hugen

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

WARKS

02-22-08

P.U BOX 1733 SALISBURY NO 21802

			- FOR	partment of Health and Nertificate of Death	, ,	ene . No. 2008	07916
· ·	Physici		Decedent's Name (First, Middle, Last) KEVIN SCOTT MOWL		2. Date of Death Month FEB 25	Day 2008 Year	3. Time of Death 10:13 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER	4b. City, Town, or Location of Death BETHESDA		4c. County of Dea	
n de	Funeral Director		5. Social Security Number 170-66-4365 6. Sex 1	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Oct . 24,	^{9. Bir} 1985 Pitt	thplace (State or Foreign cuntry) Sburgh, PA
	Maryland a-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Pittsfor		-		10d. Inside City Limits 1 □ Yes 2X No
	th with the 23a or 28a ust be noti	ral Director	10e. Street and Number 48 Falcon Trail	10f. Zip Code 14534		. Citizen of What Co USA	
36	ırs after des II", or Items xaminer m	by Funeral	11. Marital Status 14 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 2004 If Yes, Give 2008 Year or Dates:	i. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036	d within 72 hours after death with the Maryland glene. rr than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Gin	edent's Usual Occupation we kind of work done during most of work DO NOT use retired)	ding 16	b. Kind of Business	· · ·
and 21	be filed ntal Hygi of other event, t	Be	12 1 Speci 17. Father's Name (First, Middle, Last) Harold M. Mowl Jr		e (First, Middle, Ma Arrington	US Army iden Surname)	
Mary	s 1 and 2 should be f Health and Mental Item 27 is marked o other traumatic ev	To	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Run alcon Trail Pittsfo	ral Route Number, C		Zip Code)
imore,	0 O			position (Name of rematory or other place) ren Memorial Park 3/1/0		c. Location - City or ttsford, N	
Balt	permit. Page Department (Important; if any Injury or		To the second	22. Name and Address of Facility Murphy FH 4510 Wil:			
	Physician /Medical Examiner	r	resulting in death) Due to (or as a consequence of):	F BLAST INJURIES	or respiratory arrest		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, and the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence				
.O. Box 6	the che	Physician/Me		B ∐Ectopic pregnancy 5 ∐ Other <i>(specify)</i>		23d. Date of de Month	elivery Day Year
Д	gr be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac		o the cause of death? robably 4 Unknown
il Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performe 1 X Yes 2 D	prior to	utopsy findings available completion of cause of s 2 \sum No
or Vital	Physician: The ribis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	th (Check only one)		ecify)
Division (ding J. After funer	Certification:	27. Manner of Death 1 □ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 28a. Date of Injury (Month, Day Year) AUG 2 2007 UNKNO 28e. Place of injury - At home, farm, so building, etc. (Specity) BATT	Work? DWN ^M 1√2 Yes 2 □ No		ILITARY O	lural Route Number,
ш	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place		se(s) and manner a	is stated.
)	within voing	Me	29b. Signature and title of certifier	29c. License number 0101054497 (VA		FEB 26	
1	(5)		30. Name and address of person who completed cause of death (Item 23a) (Typ ELIZABETH A. ROUSE LtCo1 MC USAF	ARMED FOI ROCKVILLI	RCES INST E MD 208!		PATHOLOGY
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 8 2008 Security Signature 32. Registrar's Signature)			

DHMH 17 Rev 1/2001

7. Age (In yrs. last birthday)

10c. City, Town or Location

72

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min.

TAKOMA PARK

3. Time of Death

1948

Birthplace (State or Foreign Country)

10d, Inside City Limits

Washington DC

Dav

February

8-4-1935

8. Date of Birth (Month, Day, Year)

23.

2008

PARK

MD 20912

TAKOMA

4c. County of Death

MONTGOMERY

Physician
/Medical
Examiner

Funeral

Director

RICHARD MAY

5. Social Security Number

10a. State

577-46-4626 Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

WASHINGTON ADVENTIST HOSPITAL

6. Sex

1 M 2 □ F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALTIC

TASN GEM 31. Date filed (Month, Day, Year) FEB 2 8 2008 7660

32. Registrar's Signature

show r than "natural", or Items 23a or 28a-f st the Medical Examiner must be notified Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or other 1

Department of Heali Important: If Item 2 any injury or other once,

altimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records.

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran physician a attending photon for use as the ed by the a detached f signed I page 2 s funeral director. this After ospital c.
4 hours after dea.
7.meral Director: After the Funeral Director filled in by

DC Washington 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20032 United States 3330 12th St SE Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify Black 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Fire Fighter 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Monroe May Polly Hardy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Blanche May/ Wife 3330 12th St SE Washington DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Cemetery 20c. Location - City or Town, State 20a. Method of Disposition XXXBurial 2 ☐ Cremation 3 ☐ Removal from State 3-1-2008 Landover MD 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service License 22. Name and Address of Facility ope Funeral Home 2617 Penn Ave SE Washington DC 20020_{imate} 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): HY DOX TA

Due to (*r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. En of Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown STAGE Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HYPERTENSION autopsy performe 2 No ANEMIA 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D51121

DHMH 17 Rev 1/2001

State Registrar

within 24

CARROL

AVENUE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Month David R. Mulkey 24, 2008 February 8:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 26, 1979 6 Sex 7. Age (In yrs. last birthday) **Funeral** 220-08-5506 1 □XM 2 □ 28 Director ΜĎ Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count 1 ☐ Yes 2X No Director MD Montgomery Germantown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? o e items 23a o 17521 Charity Lane by Funeral 20874 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. United States . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American I Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic even Louis H. Mulkey ပ Deborah L. Griffith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Louis H. Mulkey (Father) 17521 Charity Lane Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem. 4 □ Donation 5 □ Other (Specify) 2008 Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 months disease or condition resulting in death) /Medical Due to (or as a conse uence of) Examiner MYDNIC CINEL many years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami attending physician and for use as the burial-trai Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has certificate has irector, page 2 autopsy perform 1□ Yes 2 XNo Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28b. Time of Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation the To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rock Research BLUD STUTE 31. Date filed (Month, Day, Year)
FFR 2 7 330 MENDHIR 2401 MA

Registrar

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryla	-	rtificate of D			eg. No. 2008	07919
15	Physicia	an	1. Decedent's Name (First, Middle, L					2. Date of Death Month		3. Time of Death
	Physicia /Medic			ay Malcho	D₩	4. 6% Tour and	and a state of Darth	Feb.2	3,2008 Year 4c. County of Deat	10:30p M
	Examin	er	4a. Facility Name (If not institution, gi Aspenwood Ass		or	4b. City, Town, or L Silver	Spring	ſ	Montgor	
5 S	Funeral Director				s. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/29/1	9. Birt 924 NY,	hplace (State or Foreign untry) New York
	put N		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	lo	MD Montgo			Spring				1 □ Yes 2 No
	r 28a-	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	untry?
	23a o ust be	ralD	14400 Homecre			209			USA	Para
980	urs after des al", or Items Examiner m	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 2 No	spanic Origin? (Spenic Origin? (Spenic Origin) Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatte event, the Medical Examiner must be notified at ance.	Completed by Funeral Director	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	16a. Deced (Give life. I Exec	dent's Usual Occupat kind of work done du DO NOT use retired) cutive As	tion uring most of worki ssistant	ing	16b. Kind of Business/ American Society	
land 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Las unknown Erler	nwein		1	18. Mother's Name Julia	(First, Middle, Ma a unkno	Maiden Surname) WN	
Maryland	1 and 2 should Health and Men em 27 is marke other traumatic		19a. Informant's Name/Relationship Marie J.Fleish		I	ng Address (Street ar 242 Wickh	nd Number or Rura	al Route Number, d Olney	City or Town, State, 2	Zip Code) d 20832
Baltimore,	Pages 1 and Hert of Hert II it is it is or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or other III or o		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	MHemoval from State D	Place of Dispo cemetery, crei osehil	osition (Name of matory or other place 1s Mem . I	% 2/29)/2008	20c. Location - City or Putnam	Town, State Valley, N.Y
Balti	permit. Pag Department Important: I any Injury o		21. Signature of uneral Service Lic	well	92	241 Colum	nbia Bl	vd.Silv		E,P.A. g,Md20910
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused the de ly one cause on each line.	ath. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	(1	1.00	O i .	A	
*	*	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):	911191	1011-0	reno	V.	
(b)	outed id ransit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e 629	Sta	SR C6	Conar	2 CITTO	ry dis	458
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a conse	equence of):					
	entificating physes as the		IF FEMALE:				 			
P.O. Box	w requires that the death cer been signed by the attendin should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 ☐Live birth 2 ☐Fe 4 ☐Pregnant at time of 9 ☐Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	s that ned by e deta		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause giver	n in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
ords	equire en sig	ed b	Pub	nmonia	Λ			1 □ Ye	es 2 No 3 P	robably 4 □Unknown
Il Records,	The law rate has be page 2 sh	Completed by	adi	rances	den	manha		24a. Was a autops perform		utopsy findings available completion of cause of s 2 □ No
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Deat			aggigted
ō	g Physer this eral di	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	11 2 DOV			ow injury occurred	assisted living
Division or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 🕅 Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of injury - At	home, farm, st	M 1□Y	/es 2 □ No	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
_	Hospital or A 24 hours after of Funeral Direct stely filled in by	Medical Ce		Physician: To the best of my k aminer: On the basis of exami and manner stated.						
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Mon	th, Day, Year)
	10		ATA P	notumedi	mo	Do	6399	9	2/25	108
	()		30. Name and address of person wh	o completed cause of death (It	em 23a) (Type,	Print)				

M.D. 18111 Prince Philip Drive Olney, Md 20832 Ata Motamedi
31. Date filed (Month, Day, Year)
FEB 2 7 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Douglas Ernest Meek 2. Date of Death Year **Physician** March 5 2008 9:50P /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Port Republic 2010 Wash Hance Road Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 214–60–6216 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Eng Tand Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner man. 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland Calvert Port Republic 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 2010 Wash Hance Road 10f Zin Code 20676 England Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinest Machine Shop 18 Mother's Name (First, Middle, Maiden Surname) ALICE Jackson EFTHE'S Lame (First Middle, Last) Be 2 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2010 Wash Hance Rod. Port Republic MD 20676 19a. Informant's Name/Relationship (Type. Print) Pansy Meek - Wite 20b. Place of Disposition (Name of cemetery crematory or other of 20c. Location - City or Town, State 20a. Method of Disposition March 6º2008 Alexandria Virginia 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Service 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Parson Fireral Home, P.A. 21. Signature of Funeral Service Licensee 1405 Broomes Island Rd. Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) Cancer Colon **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician the IF FEMALE: use a if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 ☐Unknown 1 Tyes 2 No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No or Attending Physician: The 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 TYes 2 TNo 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number D29657 29d. Date signed (Month, Day, Year) 03/06/08 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

ORIGINAL

Registrar's Signature

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Charles Judge, M.D. 110 Hospital Rd. Suite 310 Prince Frederick MD

State

31. Date filed (Month, Day, Year)

MAR 12

2008

Physic	ian	1 - For State Registrar 1. Decedent's Name (First, Middle, Last)			rtificate of	Death	2. Date of D Month	D	ay	Year	3. Time of D
/Medi	ical	Thomas Wilson Meiser	d		4b. City, Town,	or Longtion of	March		2 County	008	1057
Exami	ner	4a. Facility Name (If not institution, give street and St. Mary's Hospital	a namber)		Leonar		Death	"		Mary	
Funeral Director		5. Social Security Number 6. Sex 185-03-3301	7. Age (In yrs. 90		If Under 1 Yea Months Days		8. Date of E (Month, I 12/10)	sirth Day, Yea /191	r)	9. Birth	place (State or intry) isylvani
land ow at		Usual Residence of Decedent 10a, State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City
Mary a-f sh	iot	Maryland St. Mary's	Ca1	iforni	.a						1 ☐ Yes 2
th the or 28% e not	Sire	10e. Street and Number			10f. Zip Code			10g. C	Citizen of V	What Cou	intry?
ath w	la	44059 Fieldstone Way				20619			ited		es ican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 Ye	Decedent Ever in U ed Forces? Yes 2 ☐ No s, Give or Dates:		was Decedent of If Yes, specify Cu		gin? (Specify Yes or N , Puerto Rican, etc.)			k, White	
172 h "natu edical	ete	15. Decedent's Education (Specify only highest grade comple	ited)	(Give	dent's Usual Occ kind of work don DO NOT use retii	e durina most	of working	16b.	Kind of Bu	usiness/Ir	ndustry
within ene. than the Me	dm	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)	Sale		euj		P	aper		
filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)		1	-	18. Mother	r's Name (First, Midd			ne)	
uld be Mental rked tic ev	To B	Herman M. Meiser				Mary	Leach				
and N		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Stree	et and Numbe	r or Rural Route Nun	nber, City	y or Town,	State, Zi	ip Code)
and 2 ealth m 27 I		Thomas Allen Meiser /		2324	5 Dillow	Ct. L	exington I	Park	, Mar	y1an	d 20653
ges 1 It of H If Itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	rom State		osition (Name of matory or other p		Date	-		,	own, State
t. Partmen rtmen rtant;		4 Donation 5 Dother (Specify)	Mo				3/08/2008		ork,	Penn	sylvani
permi Depa Impo any Ir once		21. Signature of Funeral Service Licensee Kyle S. Simons	M01206				Brinsfiel Road, Lec				
A		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause							ILOWII	, ma	Approximate Interval Betw
Physician		Immediate Cause (Final	on each line.	4	Uty THY						Onset and De
/Medical		disease or condition resulting in death)	e to (or as a conseq		7 1011	174					MINUTE
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be executed ician and burial-transit	xam	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	NEUMO								U495
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requires that the sen signed by tould be detact	by	Part II. Other significant conditions contributing	to death but not res	sulting in the u	inderlying cause (jiven in Part I.					the cause of de
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The lav te has	dwc						pe pe	topsy rformed 2	?	prior to c death? 1 ∐ Yes	ompletion of ca 2□ No
. 400	Be C	25. Was case referred to medical	1823)fig	26. Place	of Death (Check only	-	40	1 163	ZLINO
Physiclan: this certific	To B	examiner? 1 Yes 25 No Hospital:	1 ☐ Inpatient 2	R/Outpatie	nt 3□ DOA C	ther: 4 🗆 Nui	rsing Home 5 Re	sidence	6 □Oth	ner (Spec	ify)
ng Pl	iuc	1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	W		28d. Describ	e how in	jury occur	red	
Attending r death. sctor: After	cati	2 Accident investigation	Diagonal Albania			☐Yes 2☐N		(0)			
after d Direct	Certification:	dotarmined 206.	Place of injury - At h building, etc. <i>(Speci</i>	ome, tarm, st fy)	геет, тастогу, опіс	е	City or 7	own, St	and Numb ate)	oer or Hu	rai Route Numb
Hospita 24 hours Funeral etely filled	Medical Ce	29a. Certifier (Check only one) Certifying Physician: 7 Certifying Physician: 7 Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete Complete C	o the best of my know the basis of examina manner stated.	owledge, dea ation and/or i	th occurred at the ovestigation, in m	time, date and y opinion, dea	d place, and due to the the time	ne cause ne, date a	e(s) and ma and place,	anner as and due	stated, to the cause(s)
To the comple	Med	29b. Signature and title of certifier	THE INC.		29c. Lice	nse number		29d. [Date signe	d (Month	n, Day, Year)
IM°		1/1/1 M	D		Doc	62937)	MA	RCH	4,	8000
1		30. Name and and a sof person who completed	cause of death (Iter	m 23a) (Type	Print)		TOWN, M				
4/		31. Date filed (Month, Day, Year)	3 Registrar's Signa								

08-01840 Joseph P. Mason

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 07922

		1- For State Registrar	_	Certific	ate of	Death			Red	. No.	200	0 0192
Physicia		Decedent's Name (First, Middle,La	st)						Date of Death		Year	3. Time of Death
edical Exami	ner	Joseph Paul Mason						N	March 4, 20	508	Tear	2246 hrs
		4a. Facility Name (if not institution, gi	ve street and number)		41	c. City, Town,		of Death			ounty of Death	
		Saint Mary's Hospital				Leonardto					Mary's	
Funeral		Social Security Number 6. S	ex 7. Age (II	n yrs. last bir	thday)	If Under 1 Y Months D	ear If Unde ays Hours	_	. Date of Birth	n(MM/DD	/YYYY) 9. Birt Foreig	hplace (State or Maryland
Director		214-32-8499	M 2 F	75	Yrs.	Wioritis	ays Hours		May 10,	1932	Cou	intry)
ý		Usual Residence of Decedent	140	A1 -	- 1							10d. Inside City Limits
w any		10a. State 10b. County		c. City, Town	or Locatio							1 X Yes 2 No
/land -f sho	tor		lary's			Leonard						
ne Maryland or 28a-f show	Director	10e. Street and Number				10f. Zip Code			10	g. Citizer	of What Cour	itry?
ith the Maryland 23a or 28a-f sho		23335 Greenbrier Ro					2065				USA	
nth wi	Funeral	11. Mantal Status 1 X Never Married 2 Marrie	12. Was Decedent Eve Armed Forces?	er in U.S.		Decedent of s, specify Cut				14	. Race - Ameri White, etc.	can Indian, Black,
er death			1 Yes 2 X d If Yes, Give Year	No		V 0 -	Na anasifu					31ack
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she sal Examiner must be notified at once.	by	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	or Dates:	ted) 16a		Yes 2 🗶			done		ecify:	
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)	- Toa.		st of working				TOD. Talle	or Dusinessii	idustry
36 bin 7 than	βle	9	, , ,	F	arm La	borer				Agı	riculture	•
21215-0036 Judd be filed within 72 hours after than Hygiener marked other than "natural", ic event, the <u>Medical Examiner</u>	Completed	17. Father's Name (First, Middle, Las	t)				18.Mother	's Name (Fi	rst, Middle, M	laiden Su	mame)	
215 oe file ntal H ked e	Be (Paul Harrison Masor	ı				1	Mary Al	berta Ba	arnes		
21 hould I nd Mer is mar	2	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (St	reet and Nun	nber or Rura	al Route Numi	ber, City	or Town, State	, Zip Code)
y, MD 21215-0036 and 2 should be filed within teath and Mental Hygiene. tem 27 is marked other that traumatic event, the Medic		Mary A. Campbell /	Sister	2	3335 6	reenbri	er Road	Leon	ardtown,	, MD 2	20650	
nore, MD 2 ages I and 2 shou mt of Health and N tt: If item 27 is n other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation 3			of Disposit	ion (Name of	cemetery,	March	ate	20c. Loc	cation - City or	Town, State
MOre Pages 1 Tent of H ant: If i		4 Donation 5 Other Specif	_			Cemetery	r	200	- 1	Leon	ardtown,	Maryland
Baltimore, permit. Pages I an Department of Her Important: If ite		21. Signature of Funeral Service Lice			22. Na	me and Addr	ess of Facilit	Matti	ngley-Ga	rdine	r Funera	1 Home, P.A.
E P P W		Muchael	Gardiner			O. Box						-
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e		death. Do n	ot enter the	e mode of dyi	ng, such as c	ardiac or re	spiratory arre	st, shock	, or heart	Approximate Interval Between Onset and
/Medical ≒xaminer			Aspiration po	eumonia								Death
.xummer		or condition resulting in death)	Due to (or as a consequ	-								
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O, e be e /sicial burial	n/Medical		AMENDED23a-b,			ME go//	3/2//0	o amn				
Box 68760, death certificate be he attending physicid for use as the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	of pregnancy		al death	3 Ectopi	c pregnancy	,		Date of delivery onth	/ Day Year
Box 68 e death certif the attending ed for use as	Physicia	past 12 months?	4 Pregnant at tim	e of death	-	er (Specify)	_ ,	, , ,				•
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Hosp 24 ho Func	alc		cian: To the best of my kr									
Division of Virol To the Hospital or Actending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	one) 2 Medical Examine	er:On the basis of examin and manner stated.	ation and/or	investigati	on, in my opin	ion, death o	ccurred at th	ie time, date a	and place	, and due to th	e cause(s)
L>F0	ž	29b. Signature and title of certifier				29c. Lice	ense number			29d. Da	te signed (Mo	nth, Day, Year)
1		Tat. Un.	mice - Pa	00,1	حبا	0.	C.M.E.			March	5, 2008	
John		30. Name and address of person who		h (Item 23a)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	72 11						
<i>∆</i> : □		Patricia Aronica-Pollak M			miner	111 Penn	Street, Ba	altimore,	MD 21201			
	tate	31. Date filed (Month, Day, Year) MAR 0 7 200	2. Registrar's	Signature	1 >	-						
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RIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 45 A.M 86 /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner Nicomico medical Cem ional Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 5 1□M 2**X**F 23 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director OMOKO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 5 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Formissione. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Nidowed 4 Divorced lac Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Oha 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) grand 20b. Place of Disposition (Name of cemetery, crematory or other place) Matthew Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Pocomoke mol 3-1-08 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bervice Smith Funeral Hore gnature eral Service Licensee POCOMUKO City, md, 21851 Box 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of): P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 22 No ate has page 2 s 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To

Division or Vital Records.

To the Hospital or Attending Physician: completely filled in by the funeral after death. within 24 hours a To the Funeral I

State

Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

D24872

ocomokeak

21851

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person TenTh 305

31. Date filed (Month, Day, Year)



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#1.PerPhys.PCC2-28-08cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 7:35 AM Horman, III 26 ruery 24, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner 100 More Social Security Number 7. Age (In yrs. last birthday) If Unde Hours 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 2 F Months Days 78-88-6130 Director Cutsh motor, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at Brookland MD 1 Tes 2 No Director 10e. Street and Number 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. as Decedent Ever in U.S. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/ in and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) J. Norman Pages 1 and 2 should permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any Injury or other trau -mother 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery In Cemetery 3/3/08 Brentwood, m.D. 22. Name and Address of Facility Peyfon Tuneral Home 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Funeral Service. Patrick St. Alex, VA 22314 Part1. Enter the disease shock, or heart failure. omplications that caused the death. Do not enter the mode of dying, such as cardiac only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) END ORGAN FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed burial-transit neumono and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HETHMA 2 No 3 Probably 4 Unknown Completed SIADM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 ⊟ Naturai Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours at To the Funeral C To the Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OR 4

State Registrar S1. Date filed (Month, Day, Year)

ESTATOILLA

32. Registrar's Signature

3001 S. Hanover Ut. Baltinore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. 19, 2008 **Physician** 3:45pmM Newman Charles Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Springhouse Assisted Living If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days 6/07/1927 1⊠M 2□F 314-24-1496 80 Indiana Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inten 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ıral", or items 23a or 28a-f show Examîner must be notified at Silver Spring MD Montgomery 1 ☐ Yes 2 🗚 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20910 609 Woodside Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 0 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1X Yes 2 No 1945
If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Completed by 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Asst.Deputy Administrator N.A.S.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Thomas Newman Ruth Thorpe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Newman-Pape/Daughter 9122 Autoville Drive College Park, Md 20740 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot chesapeake Crem. 2/26/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Md. 4 □ Donation 5 ☐ Other (Specify) 21. Signature PANTED TEP ADJUST TO THE PALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary fibrosis **Physician** 2½yrs /Medical Due to (or as a consequence of): Examiner 2½yrs. Interstitial pneumonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physiciar by Physiclan/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Atrial fibrillation should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No arteriosclerotic heart disease 24a. Was an page 2 s performed? Yes 2.2.No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) assisted 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-26-2008 00017171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Sengstack MD 3929 Ferrara Dr. Wheaton, Md 20906 31. Date filed (Month, Day, Year) gistrar's Signature State 7 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Voor **Physician** 09:45 AM FEBRUARY Josie Lee Newland 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 K F 410-48-4720 Director 09/10/1932 Mississippi Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Maryland St. Mary's Lexington Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 45864 Pine Road 20653 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Vernice Theodore Higginbotham Lelia Bessie Wiggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45864 Pine Road, Lexington Park, Maryland 20653 <u> James Robert Newland / Husband</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory
Brinsfield-Echols 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/04/2008 | Charlotte Hall, MD 22. Name and Address of Facility
Brinsfield Funeral Home, P.
Leonardtown, MD 20650-0279 21. Signature of Funeral Covins LC Edward N. Bri Brinsfield, Jr. M0052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician experial one week /Medical Due to (or as a consequence of): Examiner chronic o Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): JOSTE, I. NEWLAND Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: ase 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2010 2 ER/Outpatient 3 DOA P 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 Could not be determined 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54346 SCGaby M.D. 108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA SAJJA MD HOLLYWOOD, MARYLAND 20636 31. Date filed (Month, Day, Year) 32. Registar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#290perMD 2-27-08, EMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 10:15 pM Vincent Hamilton Penn February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 01nev If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Days Hours 1⊠M 2□F Yrs. 579-46-6556 72 January 23,1936 District of Columbia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 k Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14416 Briarwood Terrace 20853 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates:1958 -1961 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Specify. 3 Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Recording Industry Sales and Promotion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Joseph Penn Phyllis Regina Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica L. Penn - Daughter 2725 Loch Haven Drive, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sussex County 4 ☐ Donation 5 ☐ Other (Specify) 02/29/2008 Millsboro, Delaware <u>Veterans Cemetery</u> 21. Signature of Funeral S 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Euer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Acate myocardial min Due to (or as a consequence of): 4thlerescleratio Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown s contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ural", or Items 23a or 28a-f show I Ex∍miner must be notifled at

"natural",

other traumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event.

Directo

Funeral

<u>ک</u>

Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit Physician/Medical detached for Certification: To

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Completed

Be

Medical

signed by

this

After t

Director

24 hours a

within 2

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

Examiner

IF FE	MALE:	
	Was decedent pregnant	
	in the past 12 months?	
	1 ☐ Yes 2 ☐ No	
	9 Unknown	

25. Was case referred to medical examiner?

1 7 es 2 No

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 → Hinknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 \sum Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Specify)
		The oblition oblition (openin)
	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, offi building, etc. (Specify)	fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a	Certifier
	(Check onl)
	one)

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide 4 Homicide

> 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

7 2008

5 Pending investigation

6 Could not be determined

29c. License number Medical Director

29d. Date signed (Month, Day, Year) 2-27-2008

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Valve replacement

18101 Parnece lichar! 31. Date filed (Month, Day, Registrar's Signature Year)

State Registrar

			State of Maryland / Depar State of Maryland / Depar	tment of Health and M ificate of Death	lental Hygie Reg.	ne 2008	07929
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Diane Ruffin		2. Date of Death Month 2/22/2		3. Time of Death 6:30 am
	Examir Funeral Director	ner	8308 Bernard Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Fort Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Coun	lace (State or Foreign
	D	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca Maryland Prince George's Fort Washir				0d. Inside City Limits 1 Yes 2 No
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Funeral Director	10e. Street and Number 8308 Bernard DRive 11. Marital Status 12. Was Decedent Ever in U.S. If Y	10f. Zip Code 20745 as Decedent of Hispanic Origin? (Spe	Un	. Citizen of What Coun ited State 14. Race - Americ Black, White,	S an Indian,
		þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) (Give kind Divorced Year or Dates: 16a. Deceder (Give kind Divorced)	Yes 2 No Specify: nt's Usual Occupation nd of work done during most of work 0 NOT use retired)	ing	Specify: Bla b. Kind of Business/Inc	
and 212	ld be filed within lental Hygiene. ked other than " ic event, the Mei	Be Completed	College (1-4or 5+) 12 17. Father's Name (First, Middle, Last)	ial Analyst 18. Mother's Name	F € (First, Middle, Mai	ederal Gove iden Surname)	rnment
e, mary	1 and 2 should be Health and Menta tem 27 is marked other traumatic ev	To		Address (Street and Number or Rura ernard Drive Fort	Washingt		745
Баштог	permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		A Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	atory or other place)	2008	itland Ma	wr.1 on J
	Physician /Medical Examiner		23a. Part. Enter the Isease, or complications that caused the death. Do not enter shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	the mode of dying, such as cardiac	<u>Forestvil</u>	le, Maryla	Approximate Interval Between Onset and Death
8/60,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
O. Box 62	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
cords, P.	equires that I en signed by ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the under	23e. Did tobac	ne cause of death? ably 4 ☐Unknown		
итан жесс	in: The law r ificate has be or, page 2 sho	Completed	25. Was case referred to medical	26. Place of Death		d? prior to cor death?	psy findings available inpletion of cause of 21 No
0	ing Physician: After this certific Ineral director,	on: To Be	examiner? 1 Yes 2 No	3 DOA Other: 4 Nursing Ho		e 6 Other (Specify injury occurred	0
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	the Hospital or thin 24 hours after the Funeral Dir mpletely filled in In	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigated. Constitute and title of certifier.		red at the time, date	e and place, and due to	the cause(s)
	S S W T		29b. Signature and title of certifier How Min (North Control of Certifier)		F.	beb. 25 mD	2008
C	(5)	ato.		nd D WO	ldorb	MD	
	Regist		FEB 2 8 2008 (Month, Day, Year) 32. Registrar's Signature				

			For State Registrar	State of I	Marylan		artment of F		and Mental H		3000	0.71000
		19%	Registrar Decedent's Name (First, Middle)	le. Last)			lilicate of	Dealii	2. Date of D	Reg. No.	7000	3. Time of Death
	Physici		Jack	-,,	Rosen	fe1d			Month Februa	rv 26.	2008	12:06 A M
	/Medio Examin		4a. Facility Name (If not institutio	n, give street and numb			4b. City, Town, o	r Location of			ounty of Death	
100			917 Lamberton	Drive			Silver			Мо	ntgome	ry
57,	Funeral		5. Social Security Number 089-20-9329	6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. 100	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of E	irth 1919 (1917)	9. Birthi G&YY	place (State or Foreign
١.	Director		Usual Residence of Decedent			113.			10/1//	1707		
	yland iow at		10a. State 10b. County	r	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	NY Oueens		Flus	shing						1X Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 147–15 78th Av	enue			10f. Zip Code 1136	7			n of What Cou d State	
	ems (ner	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Decedent of H	lispanic Ori an, Mexicar	gin? (Specify Yes or f	10-	Race - Americ Black, White,	
36	or II	by Fu	1 □ Never Married 2 Mar 3 □ Widowed 4 □ Divorced	If Yes, Give			1 ☐ Yes 2 🔀 No	Specify:			pecify: Wh	
21215-0036	hour sal Ex	ed k		nt's Education	75.	16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/In	dustry
215	hin 72 in "na Medic	Completed		est grade completed) College (1-4	or 5+)		kind of work done DO NOT use retired		t of working			ŕ
212	d with	Som	12, (6 1-)	January Company		Own	ner-Retai	Τ		Pla	stics	
Maryland	be file d oth event	Be	17. Father's Name (First, Middle,						er's Name (First, Midd		,	
yla	d Mer narke natic	2	Efriam Rosenfe	Ld		10h Mailin	Address (Ctross		atzipora	Alter		- Code)
Ma	id 2 st Ith and 17 Is r traur	1	19a. Informant's Name/Relations George A. Teit	elbaum - Son	-law	T.			er or Rural Route Num e Silver S			
ē,	s 1 an F Heal Item 2 other		20a. Method of Disposition			1			Date	-	tion - City or T	
آ ا	Pages ent of nt: If I		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		Er^{c}	ennetery, crei eitz Ha	esition (Name of matory or other place a Chaim	ce) 2	2-28-2008	Reth	Shemesl	n, Israel
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service	Licenson		17.	2. Name and Addre	ss of Facility	^{ty} neral Dire e Pike Roc	ction kville	IMS 208	352
.%.			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cau	sed We death	h. Do not ent	er the mode of dyir	ng, such as	cardiac or respiratory	arrest,	115 20	Approximate Interval Between
	Physician [®]	8 7	Immediate Cause (Final		in line. Dirator						9	Onset and Death
	/Medical		disease or condition resulting in death)	a.	as a consequimonia		1:					
	Examiner		Sequentially list conditions	b. Pneu	monia							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	Due to (or	as a consequ	uence of):						
2	and and Il-tran	Examiner	that initiated events c									
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9	ificate g phy as the	edic		0.								
Вох	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregna		∃Ectopic pregnancy	,		230	d. Date of deliv	*
		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (specify)				Month	Day Year
P.0	res that the de signed by the a be detached f	Phy	9 Unknown			ulting in the u	ndorfying cause giv	on in Part I	22e Die	23e. Did tobacco use contribute to the cause of		
ds,	law requires that the as been signed by th 2 should be detache	by	Domentia							1 Yes 2 No 3 Probably 4		
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Records,	9 2 9	Completed							—— au	topsy rformed?	prior to co death?	opsy findings available ompletion of cause of
		e Cc	25. Was case referred to medica	al				26 Place	1 Yes e of Death (Check only	21	1 ☐ Yes	2 X No
<u> </u>	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ∏ No	Hospital:	atient 2	ER/Outpatier	nt 3 DOA Oth		ursing Home 5 Re		Ōther (Speci	daughter's
0 U	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	f 28c. Injur Wor			e how injury o		Tub Inch
Sio	Attending r death. ector: After by the fune	catic	2 Accident investi	igation not be				Yes 2□				
Division or Vital	or At after d Direct in by	Certification:	4 Homicide determ	nined Zoe. Place of	rinjury - At ho , etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office			(Street and I own, State)	Number or Rui	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifiel 1 Certifyi	ng Physician: To the be I Examiner: On the bas	est of my kno	wiedge, deat	h occurred at the ti	me, date ar	nd place, and due to the	ne cause(s) as	nd manner as	stated.
	To the H within 24 To the F complete	Medical	ne)	and manne		1			TTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTT			
	o viit	_	29b. Signature and title of certific	" h/~	,	/	D250			l	signed <i>(Month</i> 1/2008	, Day, Tear)
	~	-	7 / /	1	of do at the fitter	220\ (T	11				,	
			30. Name and address of prison Penny L. Bi k	10301 Ge	orgia	Avenue	e Silver	Sprin	g MD 20902			
	Sta Registr		31. Date filed (Month, Day, Year FEB 2 7	2008	nistrar's Signa	ature	anti)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Carolyn Jean Russell February 29, 2008 12:15 a^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F 217**-**44-7438 63 07/09/1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41908 James Richael Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Frederick Burris Jean McNey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Russell/Husband 41908 James Richael Lane, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem 03/04/2008 Leonardtown, Maryland 21. Sinnature Service Libensee 22. Name and Address of Facility Brinsfield Funeral Hornard N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Res Pinatua 2445 Due to (or as a consequence of): leven COPD Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe rmed? 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

/Medical Examiner

for funeral director, page 2 should Hospital or Attending 24 hours after deat Funeral Director: filled in by To the

Physician

/Medical

Examiner

Funeral

Director

'naturai", or items 23a or 28a-f show di-ai Examiner must be notified at

Department of Health and Mental Hygiene. Important: if item 27 is marked other than "in any injury or other traumatic event, the Market once.

Physician

within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

Be Completed by

Certification: To

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Suresh Patel, M.D. 22650 Cedar Lane Court, Leonardtown, MD 20650 31. Date filed (Month, Day, Year)

strar's Signature 3 MAR 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00062213

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

0

		for State		-	-			Mental Hygi	60	08	07932	
	1 - State Registrar Amend#31 - PerVRPCC2-28-08cr Certificate of Death							Reg. No.			3. Time of Death	
Physic	cian			1				Month	Day	Year 2008	9:00p M	
/Med Exam		Margaret A. 4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Death		4c. County		9.00p	
EAdill	inici	Villa Rosa Nurs	sing Home			Mitche:	llville		Princ	ce Ge	orges	
Funera	ıl		6. Sex 7	. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign	
Directo	r	578-52-5709	1 □ M 2 🕱 F	6	8 Yrs.	Monard Days	110010	March 16			ington, D.C.	
pus »		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Loc	ation				10	Od. Inside City Limits	
// Aarylar f show ed at	5	MARYLAND PRIM	vce Georg	200 //	10000	Mani R	101				ty∏Yes 2 ☐ No	
the 28a-	Director	10e. Street and Number	KE CENTY	100	ppek	10f. Zip Code	K U	10	g. Citizen of V	Vhat Coun	try?	
3a or st be		12588 Lord	Sterling 1	PLace		207	772		United	1 Sta	tes	
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after or ite		1 ☐ Never Married 2 ☐ Marrie	d 1 ☐ Yes 2 If Yes, Give	2 No		☐Yes 2√2 No	Specify:			Bla		
ural",	d by	3 ☐ Widowed 4 Divorced	Year or Dat	tes:			ation		30			
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withii ene.	를	Elementary/Secondary (0-12)	College (1-	4or 5+)	4 3	i . /	Practical	Nurse	Heal	th 1	Care	
Hygi Hygi other ent, t	Be C	17. Father's Name (First, Middle, L	ast)					ne (First, Middle, M	laiden Surnan			
lid be lental ked d	To B	John Nelson					SARAK	Duck	ett			
in Eq. Intelligible A. I. E. I. D. D. D. D. D. Stone of the Maryla strand 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailin	g Address (Street		ıral Route Number,	City or Town,	State, Zip	Code)	
and 2 and 2 ealth a n 27 is		ARTHUR NELS	SON / B	rother	105	14 Count	ny Ridge		Ipper P	1urlbo	ro, Mil 2077.	
of He		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from S	,,,,, C	emetery, cren	sition (Name of natory or other plac	ce)	Date 2	20c. Location -	City or To	wn, State	
Pages ment of I		4 □ Donation 5 □ Other (Sp.		Res	SURREC	tion Com	eteri 2/	27/08 (linter	o, M	1d	
permit. Pages 1 and Department of Health Important: If item 27 any Injury or other th	2	21. Signature of Funeral Service L	censee		22	. Name and Addre	ss of Facility	cor respiratory arre		, ,,1	207/7	
I SOE E	51	Xarry d.	Simme		_	5538 Mar.	Lboro Pil	ke/Forest	ville,	Ma.	20747	
		23a. Part1. Enter the direase, or of shock, or heart failure. List of	omplications that ca nly one cause on ea	used the death ich line.	n. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory arre	est,		Approximate Interval Between Onset and Deathy	
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/Medica Examine		resulting in death)	Due to (o	or as a c /sequ	uency of):	DD . 1.					1	
		Sequentially list conditions,	b. Due to/c	or as/a/consequ	uence of):	1 Justa	N				gays	
rted nsit	ŢĘ.	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury	V.	luce	Can	y V 500				1	ne de Chan	
execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (c	or as a consequ	uence of):	1		-			e number	
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The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transition.	edi											
w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome pf pregnarth 2 □ Feta		Ectopic pregnanc	v			te of delive	,	
dea he att	sicie	in the past 12 months? 1 ☐ Yes 2 MNo		ant at time of d		Other (specify)	,		IVIC	onth	Day Year	
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requi een s	Completed											
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Physician: The law rthis certificate has brail director, page 2 si	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatien	t 3 DOA Oth	or.	ath (Check only one		(0		
Physical distribution	- L	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o	of Injury	28b. Time of	1 3 DOA	4 🔀 Nursing F	lome 5 ☐ Reside			у)	
th. : Afte	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year)	Injury		rk? Yes 2 □ No					
Atter r dea ector	Eg	3 Suicide 6 Could no 4 Homicide determin	Zoe. Flace	of injury - At ho ng, etc. <i>(Specif</i>	me, farm, str	eet, factory, office		28f. Location (Sti	reet and Numb	per or Rura	al Route Number,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** YVONNE SMITH-MURRELL 1159 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
PRINCE GEORGE'S 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Months Hours 1□M 2XF 230-64-8112 Director MAY 20, 1950 BROOKLYN. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ont: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits a or 28a-f sh WASHINGTON D.C. 1 DYYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 20019 ral", or items 23a Examiner must b 3317 ALDEN PL., N.E. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1Yr CUSTODIAN PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT S. BRADLEY MARY R. OSBORN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 I ENEZ D. SMITH/DAUGHTER McCONVILLE RD.#101 LYNCHBURG, VA 24502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 🏋 Cremation 3 □Removal from State CHESAPEAKE CREMATORY 2/28/08 BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat le di Funeral Service (Gensee/ 22. Name and Address of Facility 20002 CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WDC 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** DIABETES Sequentially list conditions, the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of the same set of Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending physical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an 1∐ Yes 2 💢 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death I Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) FEB 2 8 2008

TOPOL MD 110 IRVING ST., N.W. #1850 WASHINGTON, D.C. 20010

Day, Year)

32. Registrar's Senature.

32. Registrar's Senature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please	Type or Print in B	lack	Indelible Ink	. Ensure All	Copies	Are I	Legible.	
			For State Registrar	State of Maryland		epartment of F Certificate of		-	giene Reg. No.	2008	07934
	WILL		1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
4.	Physicia		Anthony	George Stakis				Month February	Day 22		6:31 pm
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death	Tobluary		County of Death	
	LAGIIIII	CI =	Holy Cross Ho			S	ilver Spring	,		Montgor	nerv
	Funeral	2	5. Social Security Number 6. S	*	st birth	nday) If Under 1 Year	1 -	8. Date of Birl	th		
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	p		Usual Residence of Decedent								
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	a-f s	Director	Maryland Montgo	omery		F.	heaton				1 ☐ Yes 2 🖾 No
	or 28	jre.	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cour	itry?
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	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		13. Was Decedent of H	lispanic Origin? (Spe	cify Yes or No	- [14. Race - Americ	
9	after or ite		1 ☐ Never Married 2 ☐ Married	1 Mayes 2 No		1 ☐ Yes 2⊠ No		nican, etc.)		Black, White,	etc.
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9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	stec	15. Decedent's E (Specify only highest gra		16a. I	Decedent's Usual Occup	oation		16b. Kit	nd of Business/Inc	dustry
213	thin e.) je	Elementary/Secondary (0-12)	College (1-4or 5+)	,	Give kind of work done life. DO NOT use retire	d)	<i>i</i> g			
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g	al Hy loth vent	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden	Surname)	
<u> a</u>	uld b Ment Ment irkec	2	George Stavro	oulakis			Maria Sl	ilouraki	Ls		
ar)	sho s ma s ma		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street	and Number or Rura	l Route Numb	er, City o	r Town, State, Zip	Code)
Σ	alth alth		George Stakis - So	on]	L1107 Amherst	Avenue, Whea	iton, Mai	yland	1 20902	
<u>ə</u>	item		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Local								own, State
Ĕ	Page lent (nt: if		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spedia	The moval from State		m Memorial Pa	1	/2008	Rock	ville, Mar	vland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	eed /		22. Name and Addre	ess of Facility				
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	/Medical		disease or condition resulting in death)	a. Cardiopulmona Due to (or as a consequ						-	
0	Examiner			Acute Myocard							
6		Je.	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying	b. Due to (or as a consequ							
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oʻ	e executed ian and ırial-transit	Examiner	resulting in death) Last	Due to (or as a consequ							
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Division or Vital Records, P.O	or At after of Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	ie, tarr	п, эпеет, тастогу, отпсе	2	28f. Location (3 City or To	vn, State	d Number or Rura)	ai Houte Number,
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	10		Sm/C4	11/100	, 1	ng	D65069			February	22, 2008
			WILL Blomp and address of phicon who	completed cause of death /item	7201 /T	una Dant)					

State

Registrar

DHMH 17 Rev 1/2001

Sirak Hagos Lemma, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910
31. Date filed (Month, Day, Year)

FEB 2 7 2008

3 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Smitha Bhikkaji,

27

2008

31. Date filed (Month, Day, Year)

MD

1500 Forest Glen Rd Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State O	,	Certificate of L			Reg. No.	2008	079	36
Physici	an	1. Decedent's Name (First, Middle, Last) FRED D. SCOT	ım			2. Date of De Month FEB		2008	3. Time of 1748	Death M
/Medio	al	4a. Facility Name (If not institution, give street and nur		4b. City, Town, or	Location of Death	TED.		ounty of Death		
Examin	-	Shady Grove Adventi			ockvill			MONTG		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birth Cou	place (State o Intry)	r Foreign
Director		Usual Residence of Decedent	70	113.		Jan.1	8,19	938 N	.Carol	Lina
/land low at		10a. State 10b. County	10c. City, Town	or Location					10d. Inside Ci	
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Tand 1 and Health em 27 ther tr		Priscilla E. Scott 20a. Method of Disposition	20b. Place of	18519 Stra Disposition (Name of	1	Knoll Date		altne		J,MD
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To the Hospital or Attending Ph \text{within 24 hours after death.} To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the land call Examiner: On the land man	basis of examination ar	e, death occurred at the tind/or investigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause((s)
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F 3 F 8		· Chumberi Va	_ Do	De	56189	1	2	2/19/0	8	
>		30. Name and address of person who completed cau								
		Meenakshi G. Andrew	-	901 Medica	al Cente	er Dr,	Rocky	ville	, MD	20850
St	ate	31. Date filed (Month, Day, Year) 324	egistrar's Signature	Coaste						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day DORIS REVEL SLATE 3:30 P M FEB 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 33393 BOB SMITH ROAD PARSONSBURG WICOMICO | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y JULY 2, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 DELAWARE **Funeral** 1 ☐ M 2 🛛 F 1949219-56-8456 58 Director Yrs Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits riteme 23a or 28a-f shov Directo 1 ☐ Yes 2X No MARYLAND WICOMICO PARSONSBURG 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? with 33393 BOB SMITH ROAD 21849 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 X No Specify: other traumatic event, the Madical Exam WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I CHARLES WALTER REVEL RHODA WOOTTEN ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 BURLEY W. SLATE / HUSBAND 33393 BOB SMITH ROAD, PARSONSBURG, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate ō = ö 1 XBurial 2 Cremation 3 Removal from State Department of important: If eny injury or once. MILLSBORO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2/25/2008 MILLSBORO, DELAWARE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WATSON FUNERAL HOME
211 WASHINGTON STREET, MILLSBORO, DE 19966 stonge m MODE 68 nan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) breast metastic **Physician** 4000 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) inding physicien and use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery alter 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Attiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Injury hours after death. filled in by the ft investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lof 10059931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 2 CHARLES HOFFMAN, M.D. 30434 MT. VERNON ROAD, PRINCESS ANNE, MD 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar FEB 2 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $12:30 \text{ P}^{M}$ Walter 6, /Medical Seek March 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3901 A Lander Road Jefferson Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1XM 2□F Director 579-05-1187 May 16, 1916 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f sho r must be notified a 1 ☐Yes 2X No Director Maryland Frederick Jefferson 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. Int; If item 27 Is marked other than "natural", or items 23a or; 3901 A Lander Road 21755 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ral", or item Examiner r Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Year or Dates: 1940-42 white Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 owner/operator septic tank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seek ပ္ Best Louise Teske 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Cramer / daughter 3901 C Lander Road, Jefferson, Maryland 21755 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 03/07/2008 | Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Keeney & Basford PA, Funeral Home 21. Signature of Funeral Service Licenses lu MO1222 106 East Church St., Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Chronic Obstructive Pulmonary Disease many_years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Dav 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Chronic Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe 1 Yes 2 X No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural s after deural Director; Aftr 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral E

completely filled i To the Hospital 1X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

610 Ninth Ave., Brunswick, Maryland

D16675

March 7, 2008

M.D

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Wayne Allgaier

31. Date filed (Month, Day, Year)

MAR 1 2 2008

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

To the Funeral

Wedical

State

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Year

or Town, State)

29d. Date signed (Month, Day, Year)

February 26, 2008

Could not be

30 Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

32 Registrar's Signature

determined

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifie

Laron Locke MD

31. Date filed (Month, Day, Year)

8-01871 randon Wesley	_	aggero Stat	or Print in Bl e of Maryland	/ Departn	nent of	Health and				8 0794
		1- For State Registrar 1. Decedent's Name (First, Middle,L		Certific	cate of	Death		Re 2. Date of Death	g. No.	
Physicia Medical Exami	A1 17	BRANDON WESLEY	,					Month March 6, 2		3. Time of Death 1026 hrs
طبه		4a. Facility Name (if not institution, g			4	b. City, Town, or L Hagerstown	ocation of De		4c. County of Death Washington	
Funeral Director			Sex 7. Ag	e (In yrs. last b	irthday) ,9 Yrs.	If Under 1 Year Months Days	If Under 24	din	`	thplace (State or Foreign untry) LASKA
8.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow						10d. Inside City Limits
Maryland 28a-f show any d at once,	ō		INGTON	Toc. City, Tow	IT OF LOCALI		NKSTOW	N		1 XYes 2 No
the Maryl a or 28a-1	Director	10e. Street and Number 600 SOUTH EDGEWO	OD DRIVE			10f. Zip Code	21734	10	$_{ m 0g.}$ Citizen of What Cou $_{ m f U}$.	ntry? S.A.
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 \(\overline{\chi} \) Never Married 2 Marri 3 \(\overline{\chi} \) Widowed 4 \(\overline{\chi} \) Divorce	12. Was Decedent Armed Forces 1 X Yes ed If Yes, Give Year 8	?	If Ye	Decedent of Hispes, specify Cuban,	Mexican, Pue	Specify Yes or No- erto Rican, etc.)	White, etc.	ican Indian, Black,
nours a	ed by	15. Decedent's Education (Specify	only highest grade cor	mpleted) 16a		's Usual Occupationst of working life.			16b. Kind of Business/	
036 vithin 72 h ene. er than "r Medical E	ompleted	Elementary/Secondary (0-12) 12	College (1-4 or	5+)	_	CHINE OF	ERATOR		PLASTICS	COMPANY
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be C	17. Father's Name (First, Middle, La STEVEN MICHAEL S	•				TAMMIE	ame (First, Middle, N	WRIGHT	
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental sant: If item 27 is marked or other traumatic event,	욘	19a. Informant's Name/Relationship STEVEN SGAGGERO		- (1					ber, City or Town, State ${ m ERSTOWN}$, ${ m MD}$	
ore, MD as 1 and 2 sho of Health and If item 27 is her traumati	ı	20a. Method of Disposition			e of Disposi	tion (Name of cerr		Date	20c. Location - City or	
MOr Pages ent of int: If		1 X Burial 2 Cremation 4 Donation 5 Other Spec		ale	atory or oth SBORO	CEMETERY	ː 3/	11/2008	BOONSBORO	, MARYLAND
Baltimore, permit. Pages I as Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service Lice				ame and Address		Section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the sectio	NATIONAL	PIKE
Physician	V 66	23a. Part) Enter the disease or co	mplications that caused	the death. Do					O, MARYLAN est, shock, or heart	Approximate Interval
/Medical Examiner	3 Y	failule. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. a. Narcotic (n Due to (or as a cons		& metha	adone) into	oxicatio	n		Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	equerion of y						
ted 	Examiner	(Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons d.	equence of):						
(0, e be executed ysician and burial - transi	lical	XUNPENDED	AMENDED 7.28	D- E1	MT - 07	7 2/12/00 1				
x 6876 h certificat ending phouse as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	me of pregnand	₂ Fet	al death 3 [ner (Specify)	Ectopic pre	gnancy	23d. Date of deliver	y Day Year
s, P.O. Bo) irres that the deatl signed by the att	by Phys	Part II. Other significant condition	9 Unknown	th but not result	ing in the u	nderlying cause gi	ven in Part I.		bacco use contribute to	
cords, P law requires t has been sign	leted b							1Yes 24a. Was autop	an 24b. Were a	bably 4 V Unknown utopsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!	Completed	25. Was case referred to medical	1			26 Place	of Death (Che	1 ✓ Yes	med? death? 2 No 1 ✔ Y	es 2 No
Vita hysician this cer al directe	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpation	ent 2 ER/	Outpatient		Othor:		Residence 6 🗸 Othe	er: Scene
on of anding Pluth.	tion: T	27. Manner of Death 1 Natural 5 Pending		Year)	o. Time of Ir nk		y at Work? es 2 X No	28d. Describe i unk	now injury occurred	-
Divisic al or Atte s after dez il Directo	Certification:	2 Accident Investig 3 Suicide 6 X Could n determi	ot be	njury - At home,		t, factory, office bu	uilding, etc.	or Town, S	tate)	ural Route Number, City
Division of ¹ To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After t completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best of m					and due to the caus	lgewood Dr. Ha e(s) and manner as sta and place, and due to t	ted.
To th within To th compl	Medical	29b. Signeture and title of certifier	and manner stated	· and/o	mivestigat	29c. License		at the time, date	29d. Date signed (Me	
•		anla	bedu)			O.C.N			March 7, 2008	
		30. Name and address of person wh	o completed cause of	death (Item 23a	1)					

State 31. Date filed (Month, Day, Year) MAR 1.2 Registrar

OCME

2008

ORIGINAL

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 registrar's Signature

Division or Vital Records, P.O. Box 68760, Hospital

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

one

29b. Signature and

Dwight Wooster 31. Date filed (Month, Day, Year)

of certifier

18145

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

32. Registrar's Signature

DHMH 17 Rev 1/2001

Madical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^D34 **Physician** JANIE GENEVA TAYLOR February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S HOSPITAL PRINCE GEORGES LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days MAY 12, 1 □ M 2√ F Hours Min. 1932 NORTH CAROLINA 238-48-0312 75 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. Counfy 10d. Inside City Limits items 23a or 28a-f shoviner must be notified at 1 Yes 2 No Director MD PRINCE GEORGES LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 GIRARD STREET 20785 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ıral", or iten Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify 3 Widowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be JAMES BANKHEAD MARY PAULIN or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a JERRY TAYLOR/HUSBAND 8620 GIRARD ST., LANDOVER, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 3/1/2008 CLINTON, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner END STAGE LIVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DIABETES MELLITUS physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61446 82/25/08 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALAISELVI AYYANAR 9470 ANNAPOLIS ROAD, #315, LANHAM, MD 20106 KALAISELVI 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State FEB 2 8 2008 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

08-01298 Sandra Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

andra rayior		I-For State Certificate of Death Registrar	Reg.	No. 200	8 0794
Physiciar	1/	Decedent's Name (First, Middle,Last) 2.	. Date of Death		3. Time of Death
/ledical Examin À		SANDRA LAVERNE TAYLOR 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month D February 14	, 2008 4c. County of Death	2124 hrs
,		Suburban Hospital Bethesda	à	Montgomery	
Funeral Director		573-82-1269 1_M 2XF 57 Yrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bir Foreig	
any	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County			10d. Inside City Limits
A	_	Md. Montgomery Montgomery Village			1 Yes 2 X No
Maryla 28a-f d at or	Director	10e. Street and Number 10f. Zip Code		. Citizen of What Cou	-
ith the Maryland 23a or 28a-f sho		20308 Seabrook Drive 20886		nited Stat	ces ican Indian, Black,
eath w items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec Armed Forces? 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri		White, etc.	ican indian, black,
after d	g F	3 Widowed 4 Divorced If Yes, Give Year 1968—1969 1 Yes 2 X No specify:		Фр с с п.у.	hite
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired		6b. Kind of Business/ U.S. Depa	Industry Intment of
036 ithin 7; ne. r than Ledic	Completed	5+ Consultant		Veterans	Affairs
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, th. Medical Examiner must be notified at once	ဒ္ ဓ ြ	17. Father's Name (First, Middle, Last) Orville Leo Harms 18. Mother's Name (First, Middle, Last) Audrey F			
212. uld be Mental marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			e, Zip Code)
MD id 2 shoulth and in 27 is aumati		Paul Taylor (Husband) 20308 Seabrook Dr. Mo			
ore, es I an of Hea If iter		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb.	27,	20c. Location - City or	
Baltimore, permit. Pages I as Department of Hee Important: If ite	-	4 Donation 5 Other Specify: Metropolitan Crem. 200 21. Signature of Funeral Service Licepsee 22. Name and Address of Facility DeV		Alexandri	.a, vA
Depa Depa Impe		Custo: E Clark 10 East Deer Park D			MD 20877
Physician /Medical		23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Sxaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			Death
V		Sequentially list conditions, b.			
	Ę١	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
b , ,	Exa	events resulting in death) Last Due to (or as a consequence of):			
execut an and al - tra		UNPENDED X AMENDED #4bperMD2-27-08, BMW, MoCo			
760, cate be		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	y
Box 687 death certific the attending p ed for use as th	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	су	Month	Day Year
P.O. Box 687 that the death certificated by the attending detached for use as it	Physician/	1 Yes 2 No 9 V Unknown g Unknown			
ries that the signed by	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?
ords, I	ğ		24a. Was ar	24b. Were a	utopsy findings available
e law r	Completed		autopsy	ed? death?	completion of cause of
II Re	ပ္ပို-	25. Was case referred to medical 26.Place of Death (Check on	1 Yes 2	No 1 Y	es 2 No
of Vita ing Physicia After this ce uneral direc	<u>ක</u>	Tes 2 No		esidence 6 Othe	er:
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should tal	<u></u>			w injury occurred uto auto collision	
r Atter r Atter er deat irrector in by th	<u>ig</u>	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2			ural Route Number, City
Div pital o ours afl eral D	Certification:		or Town, Sta 100 Block of A	ite) Airpark Road, Gaith	sburg, MD
8 7 2 8	_ 1	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	lue to the cause the time, date ar	(s) and manner as stand place, and due to t	ted. he cause(s)
	Ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (Me February 15, 20	
5	-	30. Name and address of person who completed cause of death (Item 23a)		- coluary 15, 20	
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
Sta	w	31. Date filed Month Day 2008 32 Registrar's Signature			
Registr	εli	LANGUAGO VI. WILLIAM			

DHMH 17 Rev 1/2001

State Registrar Bruce R. Kressel, M.D. 2141 K Street, N.W., #707 Washington, D.C. 20037

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008-079 45 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Otis Thomas, III 10:30P M February21,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care of Silver Spring Silver Spring Montgomery Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number (State or Foreign **Funeral** Days Hours 1**X**) M 2□ F Months Yrs. **Director** September 2, 1952 Ohio <u> 299-48-0089</u> Usual Residence of Decedent filed within 72 hours efter death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 X Yes 2 □ No Directo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20904 13232 Copland Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black . δ 3 Widowed 4 NDivorced Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government Elementary/Secondary (0-12) College (1-4or 5+) U.S. Parole Officer 5+ Dept. of Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Thomas, Jr. <u>Carrie Elizabeth Chesley</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11703 Eden Road, Silver Spring, Maryland 20904 Brenda Hopkins-Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springdale, Ohio Oak Hill Cemetery 3-1-08 22. Name and Address of Facility Marzullo Funeral Chapel, P. A. 21. Signature of Funeral Service Licensee michael 6009Harford Road, Baltimore, Maryland21214 Markells 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner y physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No After this certificate has Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: To 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address onth, Day, 31. Date filed (A 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

DHMH I7 HeV I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month ()3 **Physician** 04^{ay} 20ď8 1139 ROGER THORNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY WMHS - MEMORIAL CAMPUS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F Nov 10, 1946 234-80-4005 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Markinal Experiment 10c. City, Town or Location 10d. Inside City Limits 1 ¥Yes 2 ☐ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 730 Furnace Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ 📉 Specify Baltimore, Maryland 21215-0036 Specify: þ white 3 ☐ Widowed 4 K Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) barber shop barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Evelyn Kesner Millard Thorne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HC 86 Box 135-C Fort Ashby WV 26719 19a. Informant's Name/Relationship (Type. Print) Geoffrey Thorne son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 3/5/2008 MD Scarpelli Funeral Home, P.A. Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, P.A. for Shaffer Funeral Home, Romney, WV 23a. Part1. Enter the disease, of shock, or heart failure. List disease if condition resulting in death) Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 7 DAYS **Physician** CEREBRAL BLEEDING /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or darrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s certificate Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Injury To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) MAR 1 2

other

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



UD

Completed by Physician/Medical

IF FEMALE

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 □Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown

5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1:33 a.M

1 XYes 2 No

Birthplace (State or Foreign Country)

Dawson, MD

2008

Baltimore

14. Race - American Indian,

Steel Mill

White

26726

Approximate Interval Between Onset and Death

DAYS

Black, White, etc.

Specify:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No

3 Probably 4 ☐ Unknown

24a. Was an autopsy performed 26. Place of Death (Check only one)

 Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

1 Matural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

23b. Was decedent pregnant in the past 12 months?

I□Yes 2□No

9 Unknown

27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence Other (Specify) NOSPLY 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 58 303

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williamle ST TOWSIN MO 21284 henres on

State Registrar

31. Date filed (Month, Day, Year)





within 24 hours after death.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.9

To the

Be

P

Medical Certification:

Division or Vital Records, P.O. Box 68760

			State of Maryland / De	·		giene	07919
			Registrar	Certificate of Death	2. Date of Dea	Reg. No. L U U U	U / J Y J
-	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Joyce Tucker Willis		Month	Day Year	3. Time of Death 8:45 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	Februar of Death	4c. County of Deat	
	Examin	e:	3142 Gracefield Road, #620	Silver Spri		Prince G	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day	h 9. Birti	hplace (State or Foreign untry)
2	Director		212-20-8728 1 M 2 F 82 Yr	s. Months Days Hours	Sept.	25, 1925 Wa	shington, D
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	faryla sho ed at	ō	Maryland Prince George's				1 ☐ Yes 2 No
	the 1	Director	10e. Street and Number	Silver Spring		10g. Citizen of What Co	untry?
	3a or	<u></u>	3142 Gracefield Road, #620	20904		USA	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexical	igin? (Specify Yes or No-	14. Race - Ame Black, White	
စ္	after or ite	/ Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 24(∑X)No If Yes. Give	1 ☐ Yes X X No Specify:			vhite
8	nours ural",	d by	XXWidowed 4 □ Divorced Year or Dates:			Openly.	TANKS OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY
<u>ب</u>	n 72 l "nat edica	Completed	(Specify only highest grade completed) (ecedent's Usual Occupation Give kind of work done during mos ife. DO NOT use retired)	et of working	16b. Kind of Business/	Industry
12	withii ene. than	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	ecretary		Governmen	nt
0	filed Hyg other ent, 1	Be C	17. Father's Name (First, Middle, Last)		er's Name (First, Middle,	Maiden Surname)	
au	Aenta Aenta rked tic ev	To B	Louis George Tucker	Ge	ertrude Mae	Hamilton	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			Mailing Address (Street and Number			
	1 and 2 Health tem 27 I			018 Berrypick La		•	
ore	Pages 1 nent of H ant: If Iter ary or oth		1X Surial 2 □ Cremation 3 □ Removal from State cemetery,	isposition (Name of crematory or other place)	Feb. 29,	20c. Location - City or	
Baltimore,	t. Pac tmen tant: ijury		, Estimates of States (Speeding)	lle Cemetery	2008	Colesville,	Maryland
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	Francis J. Coll			
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	500 University tenter the mode of dving, such as			Approximate
	Dhysisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	7 0			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Adenocarcir Due to (or as a consequence of	noma of Small Bo	owe1		8 Months
	Examiner		Liver Metas				6 Months
		ner	Sequentially list conditions, if any, seaming to immediate cause. Enter Underlying	,			
	ecute ind trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
8760,	cate be executed obysician and the burial-transit	E	Due to (or as a consequence of)				
387	physi physi the b	dical	d				
×	leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of del	iven
.O. Box	death atter	iciaı	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
O.	t the by the	hys	9 ☐ Unknown				<u></u>
Vital Records, P.	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I	. 23e. Did to	obacco use contribute to	the cause of death?
ord	equir	ted			1□\	Yes 2√∑No 3 □ Pr	robably 4 □Unknown
ပ္ပို	law r las be	Completed			24a. Was autop	an 24b. Were au	topsy findings available completion of cause of
<u> </u>	: The law cate has	Cou			perfo 1□ Yes	rméd? death? 2⊊No 1⊡Yes	2 □ No
Ë	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	e of Death (Check only o		
Division or	rding Physician: th. : After this certifica ; funeral director, p	<u>۲</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outp 27. Manner of Death 28a. Date of Injury 28b. Tir	atient of box 4 1 Nt	ursing Home 5 Resid	dence 6 □Other (Spe now injury occurred	cify)
on	nding th. : Afte fune	tion	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation	ne of 28c. Injury at Work? M 1 Yes 2			
N S	Atter	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury ⋅ At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tox	Street and Number or Ru	ural Route Number,
	tal or s afte al Dir ed in	Certification:	Juliang, etc. (Specify)		City of You	m, state)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I		29a. Certifier (Check only) 1 CertifyIng Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/				
	the him 2, the l	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h Day Year)
	7 × 5 8		16. 10		996	February 2	
	12	-	30. Name and address of person who completed cause of death (Item 23a) (T	(pe. Print)			
	-		30. Name and address of person who completed cause of death (Item 23a) (Ty Linda M. Burrell, MD 2730 Unit	ersity Blvd., #	400, Wheato	n, MD 20902	2
1	Sta		31. Date filed (Month, Day, Year) Segistrar's Signature 32. Segistrar's Signature	freely ?			
	Registr	ar	TEU W LUUU PROBLES LE	Carried States			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of	Maryland / Depa			lental Hygi	ene _	000	07000
			Registrar	Cei	rtificate of	Death		g. No.	UUU	01900
-	Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Barbara Ann Wright				2. Date of Death Month March	Day 2,	Year 2008	3. Time of Death 9:59 P M
	/Medi Exami		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	r Location of Death	11-1-011		nty of Death	7.37
4			30130 Huntt Road		Mechanic	sville			Mary's	
	Funeral	Г		Age (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Voor)		ace (State or Foreign try)
	Director	Ì	264-23-8375 1□ M 2⊠F	51 Yrs.	Wonth's Days	Hours Min.	March 6		l	Jersev
	pu ,	1	Usual Residence of Decedent 10a. State 10b. County	100 City Towns I						
	aryla shov	-	10a. State 10b. County	10c. City, Town or Lo	cation				10	Od. Inside City Limits
	he M 18a-f otifie	School	Maryland St. Mary's	Mechani						1 ☐ Yes 2 ☑ No
	vith ti	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen o	of What Count	try?
	s 23g	Funeral	30130 Huntt Road		206				USA	
	er de Items	nu	11. Marital Status 12. Was Deced Armed Forc	es?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e	
36	's aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	k No	1 ☐ Yes 2 ☑ No	Specify:		Spe	cify:	
Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	ed	15. Decedent's Education		ient's Usual Occup	ation	- 11	Sh Kind of	Wi Business/Ind	hite
15	in 72 n "na Aedic	Completed	(Specify only highest grade completed)	(Give	kind of work done of NOT use retired	during most of work	ing	ob. Killa ol	business/mu	ustry
212	with siene	E	Elementary/Secondary (0-12) College (1-4	' 1	ck Drive	, r		Tran	sport (Company
b	filed Hygi other ent, t	BeC	17. Father's Name (First, Middle, Last)		DIE DIE	18. Mother's Name	e (First, Middle, Ma			company
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If them 27 is marked other than "natural", or ftems 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	P B	Harold P. S	mith		Paula	I.		Packa:	rd
ar	sho and l	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Number,	City or Tov	vn, State, Zip	Code)
	1 and 2 Health (cem 27 is		Nola M. Libby/Sister	3013	O Huntt F	Rd. Mech	anicsvil	le. M	D 20659	9
ore	es 1 of He fitten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from St	20b. Place of Dispo	sition (Name of natory or other plac				n - City or To	
Ĕ	nit. Pages lartment of a ortant; If Ite injury or or		4 □ Donation 5 □ Other (Specify)	ue i	ld-Echols		2008 C1	narlo	tte Ha	11, MD
Baltimore,	permit, Page Department of Important; If any injury of once,		21. Signature of Funeral Service Lice see M	20052 B	Name and Addres	s of Facility	Funeral H	Home,	P.A.	, MD 20622
	京学者		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	CLOCC: st,	е натт	Approximate
	Physician	į ()	Immediate Cause (Final						1	Interval Between Onset and Death
4	/Medical		disease or condition resulting in death) a. Due to (or	as a consequence of):	icer					
	Examiner									
10.00	SPANIS T	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events c.	as a consequence of):						
	nd transi	Examine	Cause (Disease or injury that initiated events c.							
ò,	e exe		resulting in death) Last Due to (or	as a consequence of):						
8760,	cate be executed physician and the burial-transit	Physician/Medical	d							
9	leath certific attending p	Med	IF FEMALE:					-1		
Вох	attend for us	lan/		n 2 ☐ Fetal death 3 ☐	Ectopic pregnancy			1	Date of deliver Month	y Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnan 9 ☐ Unknown 9 ☐ Unknow		Other (specify)				violiti i	Jay Teal
Д.	that the d ed by the detached		Part II. Other significant conditions contributing to deat	n but not resulting in the un	derlying cause give	n in Part I	23e Did toha	cco use co	antribute to the	e cause of death?
Records,	w requires that the death certifins been signed by the attending I should be detached for use as	d by			, , , , ,			2 □ No		
Ö	v req	Completed								- 7
Re	e la has	E I					24a. Was an autopsy performe		o. were autop prior to com death?	sy findings available pletion of cause of
a	(0 L1		QE Was again referred to madical				1 Yes 2	No No	1 ☐ Yes 2	2□ No
<u>=</u>		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inc.		3 DOA Othe	26. Place of Death	-			
Division or Vital	Phys or this oral dii	2	1 ☐ Yes 2 № No 1 ☐ Inp 27. Manner of Death 28a. Date of I		OLI DOX	4 LI Nursing Ho	me 5 🔀 Residen)
On	Attending r death. ector: After by the fune	th th	1 X Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury	28c. Injury Work M 1 □ Y	? res 2 □ No	LOG. DESCRIDE HOW	injury occ	arrea	
<u>is</u>	Atter deat ctor	fica	3 Suicide 6 Could not be 28e. Place of	l injury - At home, farm, stre			28f. Location (Stre	et and Nur	nher or Rural	Route Number
Š	after after d in t	Certification:	4 ☐ Homicide determined building,	etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,	State)	in Dor or riara	riodio ridingoi,
	pspita hours inera y fille		29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and i	manner as sta	ited.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basi and manner	s of examination and/or inv	estigation, in my op	oinion, death occurr	ed at the time, dat	e and place	e, and due to	the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier		29c. License			l. Date sigr	ned (Month, D	ay, Year)
	00				HO	0557	51	31	3108	3
	Wa		30. Name and address of person who completed cause of	f death (Item 23a) (Type, F	Print)					
	. 8		Jennifer Schmidt	otrario Signatur	Leon	ardtown,	Maryland	2065	50	
	Sta Registra		31. Date filed (Month, Day, Day 3 2008	strar's Signatue						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend #26	State of per PHYS	of Marylar 02–28 –	nd / Depa - 08 ÇNM	artment of I	Health a <i>Death</i>	and Men		ene g. No. 200	8 07951
7	Physici	an	1. Decedent's Name (First, Midd	le, Last)						Date of Death Month	Day Ye	3. Time of Death
	/Medic		Ray Daniel Zi						Fe	bruary		9:20P M
	Examir	er	4a. Facility Name (If not institution 3263 Sunrise		mber)		4b. City, Town, Jeffe		f Death		4c. County of D	erick
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	**	If Under 1 Year Months Days		24 Hrs. 8. I	Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
34	Director	9	189-09-5271	1⊠M 2□F	88	Yrs.	Worlding	Hours		N 15 1		unbury, PA
	land w t		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	ty, Town or Lo	cation			, .		10d. Inside City Limits
	Mary I-f sho fied a	tor	MD Balt	imore	I	Baltimo	re					1 ∐ Yes 2 XNo
	or 28a	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of What	Country?
	23a c ust be		6756 Glenkirk	Road			212	239			USA	
36	be filed within 72 hours after death with the Maryland that lygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a be possible to event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	ried 1 ☐ Yes If Yes, Gi	2 🔀 No ve		Was Decedent of f f Yes, specify Cub I ☐ Yes 2⊠ No	oan, Mexican,	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	Black, W	
21215-0036	hour tural	q pa	3 ☑ Widowed 4 ☐ Divorced	Year or D	Dates:	16a Deced	lent's Usual Occu	nation		1	6b. Kind of Busine	White
<u>5</u>	in 72 in "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1.40r.5.)	(Give	kind of work done OO NOT use retire	during most	of working	I.	ob. Kilid of Busilie	ss/moustry
	filed within 7 Hygiene. other than "r ent, the Med	Som	12		1-401 5+)	E	lectrica	1 Engi	ineer	E	ngineeri	ng Company
Maryland	be file	Be	17. Father's Name (First, Middle,					1	,		aiden Surname)	
<u>₹</u>	should be filed vand Mental Hygies marked other tumatic event, th	ဥ	Daniel Ray Zi			405 44-35-	- Add (0)	L		orence		
<u>a</u>	nd 2 sl Iffh ann 27 is r traur		19a. Informant's Name/Relations Ann McLean, D				g Address (Street Sunrise				City or Town, State MD 217	'
ē,	ages 1 and 2 should b nt of Health and Ment t: If Item 27 is marked / or other traumatic e		20a. Method of Disposition	augneer	20b. F		sition (Name of natory or other pla		Date		0c. Location - City	
altimore,	Pages nent of i int: If Ite		1 ☑ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5		State		vn Crema		2/25/0)8 Н	lagerstow	m, MD
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Fun of Service	VIII	://:	Jo	Name and Addr hn T. Wi	ess of Facility	s Fune		me wick, MD	21716
F.	3		23a. Part1. Enter the disease, o shock, or heart failure. Lis									Approximate
	Physician		Immediate Cause (Final disease or condition		16000	tan	Failu	P				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of).				_		Few worth
	yadê a	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b	(or as a conve	uence of):	<					tow menth
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,								
o,	an and rial-tra	Exa	resulting in death) Last	CDue to	(or as a conseq	uence of):						
8/60	ficate be executed physician and s the burial-transit	edical		d								
_		Med	IF FEMALE:									
X Q Q	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live b	tcome pf pregna pirth 2 □Feta nant at time of d	ıl death 3 □	Ectopic pregnanc	У			23d. Date of Month	delivery Day Year
j.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unkn		leath 5	Other (specify) _					,
ī,	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditi	ons contributing to de	eath but not resi	ulting in the un	derlying cause giv	en in Part I.		23e. Did toba	cco use contribute	e to the cause of death?
cords	equire en sig ould b									1 ☐ Yes	2 No 3 ₽	robably 4 □Unknown
ည	law ra as be	Completed								24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
	sicerificate has to lirector, page 2 s	Con								perform	ed? death	1?
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			2□ DOA Oth		of Death Ch	neck only one)		Daughters
5	Phys er this eral dii	유	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of	3 DOA	4 □ Nurs		5 Tesiden	6 Other (S	pecify) House
202	nding th. r: Afte e fune	ation	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investi	9	th, Day Year)	Injury	28c. Inju Wo M 1	rk? Yes 2 ∐ N		2000112011011	- Injury occurred	
<u>></u>	r Atte er dea rectol by th	Certification;	3 ☐ Suicide 6 ☐ Could in determined	ined 28e. Place	of injury - At ho ng, etc. (Specif)	ome, farm, stre	et, factory, office		28f. L	Location (Stre	et and Number or	Rural Route Number,
5	ital or urs aftural Di ral Di	Çe		6					, ,))			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical	29a. Certifier 1 Certifylr (Check only one) 1 Medical	ng Physiclan: To the Examiner: On the ba and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the ti estigation, in my	me, date and opinion, deatl	f place, and on the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of th	due to the cau t the time, dat	use(s) and manner te and place, and o	as stated. due to the cause(s)
	Voith Com		29b. Signature and title of certifie	20 -			29c. Licens	e number		290	d. Date signed (Mo	onth, Day, Year)
(,	-	WM/7	my K			1)2	382	4		425/0	8
	8		30. Name and address of person	who completed caus	e of death (Item	23a) (Type, F	Zeven	not 1	Ave-	Tours	en Mi	021281
F	Stat Registra		31. Date filed (Month, Day, Year)	32.	egistrar's Signa	ture	a dist	-1/	7.0	, 500 2		

		Please Type or State o		k Indelible Ink Department of H		•	-	
		1 - State Registrar		Certificate of	Death	Re	eg. No. 2 () () 8	07952
Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
Physici Medi		Richard F. Andrews				4000	09 200	8 2309PM
Examir	ner	4a. Facility Name (If not institution, give street and nur	,		r Location of Death		4c. County of Deal	
		FRANKLIN SQUAREH 5. Social Security Number 6. Sex	7. Age (In yrs. last bi		edale	8. Date of Birth		more
Funeral Director		214-58-9803 1XM 2□F	58	Yrs. Months Days	Hours Min.	(Month, Day,	Year) Co	hplace (State or Foreign buntry) Md.
D		Usual Residence of Decedent				12-21-	1949	PIG.
arylan show d at	_	10a. State 10b. County	10c. City, Tow	n or Location 1timore				10d. Inside City Limits
he Ma 28a-f	Director	Baltimore Co.	Ба					1 X Yes 2 No
a or 2	۵	10e. Street and Number 8122 Glen Arbor Drive		10f. Zip Code	007	10	0g. Citizen of What Co	ountry?
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or ftems 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral		dent Ever in U.S.		.237	ify Yes or No-	USA 14. Race - Ame	rican Indian.
or iter		Armed Fo 1 □ Never Married 2 1 Married 1 □ Yes	2 X No	13. Was Decedent of H		ican, etc.)	Black, White	
ours a	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or Da	re ates:	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
72 h	etec	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working	7	16b. Kind of Business/	Industry
within	Completed	Elementary/Secondary (0-12) College (1	-4or 5+)		d)		7.1	
filed v Hygie ther	ပ္သိ	12th 17. Father's Name (First, Middle, Last)		Salesman	18. Mother's Name	First, Middle, N	Electronic	es
ld be ental ked o	To Be	Francis A. Andrews			Patricia		,	
2 should be and Mental is marked o raumatic eve	-	19a. Informant's Name/Relationship (Type. Print)	198	b. Mailing Address (Street				Zip Code)
alth a alth a 27 is		Diane_D. Andrews	Wife	8122 Glen	Arbor Driv	a Ralt	o Md 213	27
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 9	20b. Place o	of Disposition (Name of ery, crematory or other place	ce) Da		20c. Location - City or	
Pages ment of I ant: If Ite ury or o		4 □Donation 5 □ Other (Specify)	Jiaie	d Heart of J		13-08	Balto. N	ſd.
epart port nport ny inj		21. Signature of Funeral Service Licensee		22. Name and Addre				
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Physician /Medical Examiner		Due to (ach line. I G N O N T or as a consequence	arryth	mia		est,	Approximate Interval Between Onset and Death
198 B. C.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	or as a consequence	- cardi	omyopa	iny		
ansit	Examiner	cause. Enter Underlying		rotic co			diseas e	
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The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	in the past 12 months?	irth 2 ☐ Fetal death ant at time of death	n 3 □ Ectopic pregnancy 5 □ Other (specify) _	/		23d. Date of del Month	ivery Day Year
res that igned b	by P	Part II. Other significant conditions contributing to de	ath but not resulting i	n the underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
w require been sig should b	pel l					1 □ Ye	es 2 No 3 Pr	obably 4 🗷 Onknown
The law rate has be	Completed					24a. Was ar autops perform	24b. Were au prior to death?	utopsy findings available completion of cause of
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hys this	ဥ		npatient 2 ER/Ou		4 LI Nursing Hom		nce 6 □Other (Spe	cify)
ding F	ion:	1 E Tradital		Time of 28c. Injur Injury Worl	yat k? Yes 2 ∐ No	ld. Describe ho	w injury occurred	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Certification:	3 Suicide 6 Could not be determined 28e. Place	of injury - At home, fang, etc. (Specify)	arm, street, factory, office		If. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the bar and mann	isis of examination ar	e, death occurred at the tir nd/or investigation, in my c	me, date and place, ar opinion, death occurred	nd due to the ca	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
To 1 To 1	Σ	29b. Signature and title of certifier)/	29c. Licens		29	9d. Date signed (Mont	
		· Med to	pC.	D54	1428		3-10-	2008
1		30. Name and address of person who completed cause						
		ORMICHAEL PIPKIN GOO 31. Date filed (Month, Day, Year) 32. Re	OO FRANK gistrar's Signature	Lin Soual	'E DR	Balti	more in	d 21237
Sta Registr		32. N	gistral s Signature	hail.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland		artment of H rtificate of I			ental Hy	giene	2008	0.7	953
		16	Registrar 1. Decedent's Name (First, Middle, Language)	ast) A				Dealii		2. Date of De	Reg. No		3. Time	of Death
	Physic /Medi		SHAROW	EA	NDE	RSO	N			1 Arzi		2008	130	PM
	Exami		4a. Facility Name (If not institution, gi	ve street and number)	1.1		4b, City, Town, or	Location o	of Death	-		. County of Deat	h	
*		м	5. Social Security Number 6.	Sex 7, Aq	e (In yrs. las	et hirthday)	If Under 1 Year	If Under	0/0C	8. Date of Bir		N/A	h-l (04-4-	
b	Funeral Director		,	1 M 2 F	41	Yrs.	Months Days	Hours	Min.	(Month, Da	ay, Year)	Co	hplace (State untry)	e or r-oreign
	pu ,		Usual Residence of Decedent 10a, State 10b, County			Town and a				AUG. I	117	OO MD		
	Aaryla f shov ed at	ō	,			Town or Lo							10d. Inside 1 ☐ Ye	City Limits es 2 □ No
	r 28a-	Director	MD N/A 10e. Street and Number		BA	LTIM	ORE 10f. Zip Code	_			10g. Cit	tizen of What Co	untry?	
	th with 23a o 1st be		2209 WHITTI	ER AVE.			2	1217				USA		
	er dea tems ier mi	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Ori an, Mexicar	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Ame Black, White		
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show idlom Examiner must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	No		1□Yes 2□No	Specify:				Specify: B1	LACK	
21215-0036	72 hou nature iical E		15. Decedent's E (Specify only highest gr	ducation			dent's Usual Occupa		t of working			ind of Business/	ndustry	
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d 2	e filed val Hygie other t	ပိ	GED 17. Father's Name (First, Middle, Las	t)		RE	CEPTION		er's Name	(First, Middle,				
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other than "natun other traumatic event, the Medical	To Be	CHARLES P. AN	DERSON			ĺ			S HAN		,		
lary	2 should be and Mental is marked and and and and and and and and and an	-	19a. Informant's Name/Relationship				g Address (Street a							
	1 and 3 Health em 27 Ither tra		FRANCES ANDERS	ON/mother			9 WHITT	IER A		BALT(
Baltimore,	0		1 □ Burial 2 □ Cremation 3 □ 4 ☑ Donation 5 □ Other (Speci		cen	netery, crer	natory or other plac	i i				ocation - City or	·	
altii	- # # # -		21 Sympture of Funeral Service Lice		KIN	22	M.PK. . Name and Addres	s of Facilit	v	2008	200	LTO.CO,	MD.	
8	permi Depar Impor any Ir		Demadine	1. Acre	way		ALVIN B.						1212	
П			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	ie.							J, FID.	pproxim Interval B Onset and	etween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a			NIAL	ME	0 2	RRHA	GE		26	h Rs
	Examiner			Due to (or as	a consequei	nce or):								
	D 10 =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	iče Jij.								
	and laterals	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequer	nce of):								-
68760,	res that the death certificate be executed gined by the attending physician and $\overleftarrow{\mathcal{R}}$ be detached for use as the burial-transit	edical E		- d										
89	rtificat ng phy as the		15.55			_								
gox	ath ce ttendii or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	eath 3	Ectopic pregnancy				- 1	23d. Date of deli Month	very Day	Year
P.O. Box	the de / the a ched f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deal	th 5□	Other (specify)					MOILII	Day	real
ď	s that ined by e deta	by Ph	Part II. Other significant conditions	contributing to death bu	ıt not resultii	ng in the ur	derlying cause give	en in Part I.		23e. Did to	obacco u	use contribute to	the cause of	death?
Records,	w require been sig should b		-							10	Yes 2	□ No 3□ Pr	obably 4.	Onknown
ည္တ	has be	Completed								24a. Was	osy	24b. Were au	topsy finding	s available cause of
a F	n: The ficate r, pag									perfo 1∐ Yes	rmed?	death? 1 ☐ Yes	2□ No	
Vital	/sicial	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆 FB	l/Outpatien	3 DOA Othe	r.		(Check only o		о Пон (о		
יסר	nding Physician: The la th. :: After this certificate hac e funeral director, page 2	-1	27. Mannar of Death	28a. Date of Injur (Month, Day	y 28	8b. Time of Injury	28c. Injury Work			8d. Describe		6 □Other (Spec ry occurred	erry)	
Sio	tendlr eath. tor: Al	catic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n			M 1 1 1	res 2□1	No					
Division or	I or Attendated differ death	Certification:	4 Homicide determined		ry - At home : <i>(Specify)</i>	e, farm, stre	et, factory, office		28	8f. Location (5 City or Tov	Street an vn, State	nd Number or Ru e)	ral Route Nu	mber,
	ospita hours uneral ly filled		29a. Certifier 1 certifying Pt	nysician: To the best of	of my knowle	edge, death	occurred at the time	ne, date an	d place, a	nd due to the	cause(s)) and manner as	stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	l edical	one)	miner: On the basis of and manner sta	examination ted.	and/or in\			tn occurre					
	5 Wilt	Σ	29b. Signature and title of certifier	USLA /	41)		29c. License	number	34		29d. Dat	te signed (Month	n, Day, Year)	8
,			30. Name and address of person who	completed cause of de	eath (Item 29	Ba) (Type, F	Print)	. 6-6			1 14	wui 1	1200	
	Ч		Jos. 6057	A 30	5	T.PA	Print) PL	ne	134	HOM19	NE	171) 6	3150	2
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur									

Registrar
DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, s after dea. rai Director; Aftr filled in by within 24 hours a To the Funeral I completely

21215-0036

Maryland

DHMH 17 Rev 1/2001

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier.

31. Date filed (Month, Day, Year)

ORIGINAL

Sinai Hospital

MID

⊋egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stroud

MAR 1 2 2008

t 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

-000

29d. Date signed (Month, Day, Year)

2008

MARch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 2877 3-11-08 yt.

State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No.ZUU8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lenore B. Albert **Physician** PONORE /Medical 2008 MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ARNOLD FUTURE CARE NESAPEAKE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year 06/10/1905 Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours 577-40-4948 102 Director RUSSIA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 □Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1135 UNIVERSITY BLVD. WEST 20902 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel mortant: If Item 27 is marked other than "natural", or itel with Injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify WHITE Completed by Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ISRAEL JACOBSON** SOPHIE RABKIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN RODBELL / GRANDSON 310 JENNINGS ROAD, SEVERNA PARK, MD 20b. Place of Disposition (Name of KIRG DAVI Blace)
KIRG DAVI Blace)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) 03/11/2008 FALLS CHURCH, VA 2 Signature of Funera Cervic Cicent ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease of complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ISCHEMIC ZHOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. English of the Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🦟 physician and s the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENTIA 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed POTHYROIDIS NI Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 20 No Other: Certification: To 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) s after death.

Il Director: Af
id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🖵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46360 TOTORANS HIGHWAY MILLORS VILLAMO th, Day, Year) MAR 12 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Barnwell Handy Gertrude 03 07 2008 7:35p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Year) 20 8. Date of Birth (Month, Day, 05 30 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 X F 213-14-4151 Director 87 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 U.S.A. 1311 East Madison Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Yes 💥 No þ Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12)
12th grade College (1-4or 5+) Public Schools permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other tru any Injury or other traumatic event, the once. Cafeteria Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Hilda Onley John Handy 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4700 Ridgeway Ave, Baltimore, Md 21206 Veronica C. Barnwell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State Arbutus Memorial 3/15/08 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West Part 1. Enter the 15 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) q Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 Nhknown Completed 4b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Certification: To 1 Yes 2 No 6 Dother (Specify 2 ER/Outpatient 3 DOA 27. Man r of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

2

2008

5

Baltimore, Maryland 21215-0036

Box 68760;

P.O.

Records,

Division or Vital

29c. License number

29d. Date siggled (Month, Day, Year)

08-01953 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Beran 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 9, 2008 1621 hrs BERAN Medical Examiner JOSEPH J. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2108 East Madison Street Baltimore N/a 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Social Security Number **Funeral** Foreign Country) MARYLAND Months Days Hours 219 10 7470 Director 85 1X M 1-28-1922 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 X Yes 2 No BALTIMORE MD n/a 28a-f show notified at once, death with the Maryland Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21205 USA 2108 EAST MADISON STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 X No Yes WHITE Yes 2 X No specify: If Yes, Give Year Specify Widowed Divorced permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medic II Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 DEPT STORE APPLIANCE 12 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) MARY E. FAJMAN JOSEPH Μ. BERAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY CASTLE COUSIN 4 PEQUOT DRIVE BEL AIR, MARYLAND 21014 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Removal from State 1 X Burial 2 Cremation 3 HOLY REDEEMER CEM 3/13/08 BALTIMORE, Other Specify: Donation 5 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed the attending physician and led for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Box 68760, 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death Month 2 past 12 months? Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 9 23e. Did tobacco use contribute to the cause of death? signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, s been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other4 Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes After 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 🗸 Natural Yes 2 No Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined 4 Homicide

e Hospital or Attending Physician: 24 hours after death Division of Vital To the Funeral

2 State

Registrar

29a. Certifier , (Check only

Signature and title of certifie

Laron Locke MD.

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year) EUUO 1

me and address of person who completed cause of death (Item 23a)

and manner stated.

Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 10, 2008

08-01879	
Jerry Edmond Bennett	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia		. Decedent's Name (First, Middle,Last)		Date of Death Month Day	v Year	3. Time of Death 1800 hrs
edical Exami			ennett City, Town, or Location of Death	March 6, 2008	4c. County of Death	
3 '	•	a. Pacifity Name (if for institution, give sales and	City, Town, or Location of Death Saltimore		40. Godiny of Bodin	
		207 Atriol Gate Larie Apt. A	If Under 1 Year If Under 24Hrs.	. 8. Date of Birth (M	M/DD/YYYY) 9. Birth	place (State or
Funeral Director	1	062-58-9652 1XM 2 F 37 Yrs.	Months Days Hours Min.		70 Foreign	1
any		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Limits
*		MD NA Baltim	ore			1 X Yes 2 No
Aaryland 28a-f show	ector	10e. Street and Number	Of. Zip Code	10g. 0	Citizen of What Count	ry?
th the Maryland 23a or 28a-f sho	Ë	923 Cooks Lane	21229	ļ	U.S.A.	
with t rs 23a		11, Marital Status 12. Was Decedent Ever in U.S. 13. Was D	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ White, etc.	an Indian, Black,
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215 e filec tal Hy ked of	Be	Dolfo Bennett	Martha	Parson		
21; buld b 1 Men s mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or			
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once.			ooks Lane, B	altimore	Md 2] 0c. Location - City or	229 Town State
ore, M es 1 and 2 of Health If item 2 ther traun		1 TV Rurial 2 Cremation 3 Removal from State crematory or other	r place)			
imo Pages ment o tant:		A Denotion 5 Other Specific King Memo	rial Park 3/	12/08 R	Randallst	own, Md
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licerisee 22. Name of Mar	me and Address of Facility Ch F/H West			03035
		23a. art I. Enter the disease, or complications that and the demn. Do not enter the	O Wabash Ave	Baltin or respiratory arrest,	shock, or heart	21215 Approximate Interval
Physician Medical		ilure. List only one cause on each line.				Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):				
		Sequentially list conditions, b.				
	ner	if any, leading to immediate Due to (or as a consequence of): Cause. Linter Underlying Cause				
11/	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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e exection a	Medical	UNPENDED AMENDED				
760, icate be exe physician a	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	al death 3 Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year
Box 687/ e death certifica the attending pied for use as th	sician/	past 12 months?	al death 3Ectopic pregr er (Specify)	_		- 4
Box death he atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown				Use a see of dooth?
that the d	y Phy	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		acco use contribute to	bably 4 Unknown
Cords, P.O Law requires that has been signed be 2 should be detae	d by			24a. Was an		utopsy findings available
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ecc The lay ate ha	E			1 ✓ Yes 2		es 2 No
tal Rection: The certificate ector, page	Bec	25. Was case referred to medical	26.Place of Death (Chec			0
Vit; hysici this c	일	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			esidence 6 V Othe	er: Scene
Division of Vital Records, P.O. has or Attending Physician: The law requires that the stafter death. In a fire death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	٦	27. Manner of Death 1 Natural 5 Reading FOWND: 28a. Date of Injury FOWND: Pay, Year) FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD: FounD:	jury 28c. Injury at Work? 1 Yes 2 ✓ No	Subject shot		
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ivis	Certification:	Specify) Multi Family Ant	t, factory, amor containing, over	or Town Sta		
ospita hours	ပြီ	4 Homicide 29a, Certifier A County in Physician To the best of my knowledge, death occurr	red at the time, date and place, a	nd due to the cause	(s) and manner as sta	ited.
Division of Vital Records, P.O. Box 68760, To the Inspiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigati	on, in my opinion, death occurred	d at the time, date ar	nd place, and due to t	he cause(s)
To To To Con	Me ∣	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
		Don molinal, mis	O.C.M.E.		March 7, 2008	
2		30. Name and address of person who completed cause of death (Item 23a)				
A		Donna M. Vincenti, MD Assistant Medical Examiner 111	Penn Street, Baltimore,	MD 21201		
	state	10 11 12 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
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			for State Registrar	State of Ma	iryiaria /		tificate of				Reg. No.	2008	Ul	154
		1	1. Decedent's Name (First, Middle, Last)							2. Date of De	eath Day	Year	3. Time of	Death
Physician /Medical			Beatrice Ber				March	9 9	2008	8:45	P M			
	Examiner 4a. Facility Name (If not institution, give street and number)				Ĩ	4b. City, Town,	or Location	of Death		4c.	County of Death			
		Dove House Hospice Care Westminster								C	arroll			
F	uneral		5. Social Security Number 6. Sex	irthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. Birth	place (State o	r Foreign		
	irector		251-05-8340	M 20XF	85	Yrs.	World Days	Tiodis		Apr. 11			ginia	
D			Usual Residence of Decedent										n i troite	
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Ę.	or 28)ire	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Cou	intry?	
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dea	ems or mu	ne	11. Marital Status	Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify Cul	Hispanic O	rigin? (Spe	cify Yes or No Rican, etc.)	o	 Race - Amer Black, White 		
affer	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give				1 ☐ Yes 2 No Specify:					Specify: Wh		
G Z IZ IS-UUSO filed within 72 hours after death with the Maryland Hvoiene	ral", Exa	d by	3 ☐ Widowed 4√☐ Divorced	Year or Dates:	ear or Dates:									
ה ה ה	natu dical	ete	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16	a. Deced (Give	ent's Usual Occu kind of work done OO NOT use retire	pation during mo	st of workir	ng	16b. Kir	nd of Business/I	ndustry	
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arylan should be	arke	2	Hugh Benjamin							Mae Bl				
2 sh	is m		19a. Informant's Name/Relationship (Typ	e. Print)	19	b. Mailin	g Address (Stree	t and Numb	er or Rura	l Route Numb	ber, City or	ty or Town, State, Zip Code)		
and and	n 27 ner tr		John Wayne Bishop	/Son			Anfred	Drive				0723		
Ses 1	perinit. Tages I ain 2 should be filed within 72 frouts after death with the waryfall funderdrent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemei	ery, cren	sition (Name of natory or other pla	ace)	D	ate	20c. Lo	cation - City or	own, State	
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Dallillor bermit. Pages			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A.											
u % č	그 등 등		anico	//	M01103	_	13 Talbo					D 2070		
	hysician /Medical ixaminer		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)									e ween		
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			resulting in death)	Due to (or as	oonsequeso	o of) : /	0-1/	11	1				7.0	-1
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tending eath.	or: A	atio	2 Accident investigation				_	Yes 2						
r Att	irect by t	Certification:	3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Specify) 28f. Location (Street and Number or Notice building, etc. (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Specify) 28f. Location (Spe							d Number or Ru)	rai Route Num	nber,		
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₽	₽ 8	-	29b. Signature and title of certifier				EGG. EIGEI	o .minibel			17 1	110/7	JUX"	
			/					D6303	L		2/	1010		
15	5		.30. Name and address of person who co	mpleted cause of de	eath (Item 23a	(Type, I	Print)	1411	F7	1/15/1	mins	to M	2115)
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	Sta Registr		MAD 1 2 2008	Marks o		6000	R. J.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 19:45 PM and /Medical 2008 4a. Facility Name (If not institution, Examiner give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Mar. 26, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) WV **Funeral** 1 № M 2 🗆 F 234-50-8211 74 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Laurel Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō pe 439 Yellow Spring South 20724 USA 23a r than "natural", or items 23athe M. dical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 函Yes 2 □ No 1 9 5 3 − If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No white ğ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) filed within Hygiene. Elementary/Secondary (0-12) Manufacturing s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 is marked other th Electrical Engineer permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mac Bragg Vossie Ganielle Phillips ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sue Bragg/Wife 439 Yellow Spring South, Laurel, MD 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State March Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem. 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. A. Keir Skiles 313 Talbott Ave., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** late Yelogenous disease or condition resulting in death) Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner July to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 1☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) . Manner of Death After t 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 5 Street Greene 10 anie 31. Date filed (Month, Day, gistrar's Signature Year) 32. State 2008 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UUR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Norma Mott Berry March 6:00PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rennaissance Gardens Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Min. Hours 578-30-5152 1 □ M 2√2 F 81 MO Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3112 Gracefield Road, PV-114 20904 USA Items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Examiner 72 hours after 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3€Widowed 4 Divorced 'natural", Completed permit. Pages 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event". traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Mott Eleanor Mueller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grant H. Berry/ Son 6612 Jacks Ct., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12, March 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 2008 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01053 313 Talbott Ave., Laurel, MD 20707 23a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ardiomyopat /Medical congestive heart failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be

death. To the Hospital or Attenwithin 24 hours after death To the Funeral Director:

2

Certification:

Medical

POLEEN

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 -Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LTHUMANA

, 3110 GRACEFIELD ROAD SILVERSPRING MD 20904

State Registrar

U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕦 🗓 🖇 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LEYA BOGATYRYEVA 13:45 march 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Bolt most 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗶 F Days Hours 220-37-6594 85 11/26/1922 Director RUSSIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No MD Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ь pe 3615 FORDS LANE, #215 21215 Funeral USA "natural", or items dical Examiner mo Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No 9 Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** SECRETARIAL Aith and Mental Hv. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NISON UNOBTAINABLE UNOBTAINABLE UNOBTAINABLE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMARA BOGAT / DAUGHTER-IN-LAW 2514 LIGHTFOOT DRIVE, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or <u>=</u> 5 BALTO HEBREW CONG. 03/11/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PI

23a. Part1. Enter the discussion of the complete control of the complete control of the complete control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final Herite myocardia intarcoso-**Physician** disease or condition resulting in death) da /Medical Due to (or as a consequence of) Examiner de Un Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of): P.O. Box 68760, physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 **(**No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 TYes 2 TNo To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

OLGA SZÁLANSY, MD 31. Date filed (Month, Day, Year) MAR 12

Sralam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2401 W. BELVEDERE AVE., BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Roy Carlos Copeland 17:07PM March 08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES HOSPITAL BALTIMORE 5. Social Securify Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1XIM 2□ F 218-64-1570 48 Director Sept. 25 . 1959 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5505 Summerfield Avenue 21206 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give --Year or Dates: Specify: Black 'natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2XNo þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev Cliff Washington Barbara Jean Copeland 19a. Informant's Name/Relationship (Type. Print)
Steve Copeland / Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5505 Summerifeld Avenue; Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Carmel Cemetery 03/15/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Encephalopany 10 days /Medical Due to (or as a consequence of) **Examiner** lodays HYPOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient L_o 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day 1 Natural within 24 hours aren
To the Funeral Director: Aftr 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

OPELAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALLIKA, ANGITIPALLI STAGNES 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

Mallika. A

29c. License number

P 22257

29d. Date signed (Month, Day, Year)

, 900 S. CATON AVENUE, BALTIMORE

March 08 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ivi	-		tificate of L		INEIILAI	Reg. N	2008	07964	
T	Physicia	an	1. Decedent's Name (First, Midd David N. Outler						2. Date of Month Feb.		^{Jay} 2008	3. Time of Death 7;55 A. M	
	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								lc. County of Death		
Alma			Gilchrist Hospi		Towson 2 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs					of Righ	Baltimore 9. Birthplace (State or Foreig		
	Funeral Director	- 1	5. Social Security Number 217–14–0015	6. Sex 7. Ag	7. Âge (In yrs. last birthday) 89 Yrs. Months Days Hours Min. 89 Yrs.					b. Date of Birth (Month Day Year)			
laryland 21215-0036	/land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
	ne Mary 8a-f sh otified	Director	MD n√a Baltimore							100 (ty∏Yes 2 □ No 10g. Citizen of What Country?		
	n with the	al Dire	10e. Street and Number 2808 Presstman Street 21216							109. 0	USA	nu y s	
	should be filed within 72 hours after death with the Marylar to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2√2 Ma 3 □ Widowed 4 □ Divorce	Armed Forces? Arried 1 Tyes 2 Tyes. Give	s 21∑No Give 1 □ Yes 21∑No Specify:			(Specify Yes o erto Rican, etc	or No- :.)	14. Race - American Indian, Black, White, etc. Specify: African-American			
2-0	72 hou "natura	Completed	15. Decede (Specify only high	ent's Education est grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)		vorking 16b.		Kind of Business/Industry				
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nd	oe filed wi tal Hygien d other th svent, the	Be C	17. Father's Name (First, Middle	e, Last)				18. Mother's N	Name (First, M	iddle, Maid	en Surname)		
ryla	nould be d Mental narked o natic eve	은											
<u>8</u>	nd 2 slath an alth an 27 is r		Elinor M. Nickens		I		Presstman S						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		20a. Method of Disposition Fnt 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 1 Other (3 □Removal from State	20b. Place o cemete	f Dispos	sition (Name of natory or other place m. Park	e)	Date 27-08	20c.	Location - City or T butus, MD	own, State	
Baltir	permit. F Departm Importar any Injur		21. Sign the of Funeral Service		Occh	22	. Name and Addres 200 Liberty	Rd., Rat	Wlie Fur MalIsto	reral H	lane P.A. of 21133	Balto. Co.	
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between										
V	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SOURN	10US CE	-u	CANCER					Onset and Death YEARS	
	/Medical Examiner		Due to (or as a consequence of):									•	
	5. / E	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):									
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	ertifica ling ph e as th		IF FEMALE:	220 Hugo outcom	o of prognancy						and Data of deliv		
.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year		
Δ.	ires that the de signed by the a	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e.	23e. Did tobacco use contribute to the cause			
COL	w require been sign	Completed								Was an	24b. Were au	topsy findings available ompletion of cause of	
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or	Physl rthis c ral dire	은	1 Yes 2 No 27. Manner of Death	28a. Date of In		Time of	IL 3 DOX	4 🗀 Nursin	-		e 6 Other (Special Office of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Con	eity) HOSPILE	
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medical	ying Physician: To the bes al Examiner: On the basis and manners	of examination a	je, deat nd/or in	h occurred at the til vestigation, in my o	me, date and p opinion, death o	lace, and due occurred at the	to the cause time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certif	fier			29c. Licens				Date signed (Month		
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	6		30. Name and address of person DANIEUE POBS 31. Date filed (Month, Day, Year MAR 1.2)	on who completed cause of	6565	(Type,	HARLES.	ST. Su	UTE 209	i BA	LTIMORE.	110 21204	
	Sta		31. Date filed (Month, Day, Yea	ar) 37 Regis	trar's Signature	Son	uli		· · · · · · · · ·				
	Regist	rar	MAR 12	Z ZUUO		1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28b per ne 9877 3-11-08 yt Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:40 a.[™] **JOSEPH** CARROLL 9,2008 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Baltimore Gilchrist Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 24,1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Maryland Months Days Hours X M 2□F 88 220-05-8750 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director n/a Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. 5402 Willowmere Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 🌠 No WW 11 Specify: þ 3 Widowed 4 □ Divorced 16b. Kind of Business n us ry Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Veterans Administration Lawyer Pages 1 and 2 should be filed vent of Health and Mental Hygicint: If item 27 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll Delia McDonnell Bernard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Ellen Marie Carroll (Daughter) 5402 Willlowmere Way Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 3-14-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Sign 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Immediate Cause (Final dayo **Physician** ehydrat disease or condition resulting in death) /Medical Due to (or for consequence of): week Examiner ination Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): the death cortificate be exer ttending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Por Month Dav Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan has certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Wither (Specify) HOSPICE Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After Certification: Division Natural 5 ☐ Pending investigation all at 1 Yes 2 No 25/2008 unknown 2 Accident 3 ☐ Suicide completely filled in by the Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide assisted winy facility 6451 N. Charlesst, Balto 21304 Brighton Gardens Certifying Physician: To We best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my of inion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 03/09/2008 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 W. Towartown Blur/Balfond 21204

State Registrar 31. Date filed (Month: Day, 'Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month **Physician** 4:45 PM Vivian Lee Crouse 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Apr 3, Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Min Country) 1 □ M 2 🗓 F 73 1934 215-30-9182 Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 1 □ Yes 2 🛣 No Eldersburg Director Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 21784 6231 N. Walnut Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. White 3altimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced "natural", Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary A. Linaberg Gilbert L. Wilt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6231 N. Walnut Avenue Eldersburg, MD 21784 Gordon H. Crouse (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 □ Cremation 3 □ Removal from State Crestlawn Mem Gardens 3/14/2008 | Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Blian M00764 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 1 mth Hommoerayic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any loading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an pate has l autopsy nerformed death? 1 ☐ Yes 2□ No After this certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P21898 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMOR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

MAR 12

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 24b per doc 877 3-11-08 vt.
State of Diaryland Bepartment of Health and Mental Hygiene

			1 - State Registrar	Otate of Mai		rtificate of		, ,	Reg. No. 20	08 07967				
	Physici	ian	Decedent's Name (First, Middle, La ROBERT	L.	CUNNING	нам		2. Date of Dea Month	Day Y	3. Time of Death				
/Med Exam			4a. Facility Name (If not institution, give		COMMING		r Location of Death	March (08, 2008 4c. County of	7:15 p ^M				
	LAGIIII	iei	Mariner Health	and Rehabili	tation		Burnie		Anne	e Arundel				
-	Funeral Director			Sex 7. Age (In yrs. last birthday, 84 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Jan. 2	Year 1924	B. Birthplace (State or Foreign Country) Maryland				
036	Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State Maryland Anne An		0c. City, Town or Lo		altimore			10d. Inside City Limits 1 □ Yes 2 No				
	ith with the 23a or 28a ust be not	Funeral Director	10e. Street and Number 527 Cedar I	Hill Road		10f. Zip Code	21225		10g. Citizen of Wh USA	at Country?				
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notifled at	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Mayes 2 No If Yes, Give Year or Dates: Www.	V 2	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	ecify Yes or No- Rican, etc.)	Black, Specify:	American Indian, White, etc. White				
21215-0036	d within 72 h giene. r than "natt the Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		(Give	edent's Usual Occup e kind of work done DO NOT use retired onductor	pation during most of work d)	sing	Western Rail	Maryland				
Maryland 2	12 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, the Mec	To Be C	17. Father's Name (First, Middle, Last Free) derick Cunni	ingham		18. Mother's Nam Carie	e (First, Middle, Bowman	Maiden Surname)					
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Jerry L. Cunni		1) 339	ing Address (Street Antietam	Drive, Ha	gerstow	n, Md. 2	21742				
			20a. Method of Disposition 1	fy)	Arlingto	ematorý or other plac n Natl. C	em. 3/25			n, Virginia				
Ball	Depart Depart Import any In		21. Signature of Funeral Service Lice							21225-1856				
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	se or condition ing in death) Due to (or as a consequence of) Due to (or as a consequence of)										
68760,	rificate be executed ig physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence of):					U				
O. Box	eath cer attendir for use	ρ Σ	b	ed by Physician/Medical	hysician/Me	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Mont	
rds, P.	w requires that the deben signed by the should be detached				Part II. Other significant conditions	contributing to death but	not resulting in the t	underlying cause giv	en in Part I.			ute to the cause of death? Probably 4 □Unknown		
al Records,	The ate has bage	Completed							rmed? pri	ere autopsy findings available or to completion of cause of att? X No				
Vital	Physician: this certificatal director, j	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	a E SP/Outratio	ont 30 DOA Oth	26. Place of Dear			4-10-4				
0	ding Phy. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	2 ER/Outpatie	III 3 DOA	4 Nursing H		dence 6 □Other now injury occurred					
Division	Attender death	Certification:	1 Avatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not to 4 Homicide determined	on De 280 Blace of injury	- At home, farm, si	M 1□	Yes 2 No	28f. Location (S	Street and Number	or Rural Route Number,				
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Cer	29a. Certifier (Chock only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within.	Mec	29b. Signature and title of certifier	and manner state	MD	29c. Licens	se number	7	29d. Date signed	(Month, Day, Year)				
4	11		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	, Print) 2 W , M /	APLERD	LINT	HICUM	MD 21090				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 2 2008 32 Chistrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	
Examiner	

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physiciar /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

D Registrar

	1 - State Registrar	Cert	ificate of D	eath		Reg. No.	2008	07968				
cian	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Day		3. Time of Death 2:05 p м				
lical	VIOLA CATHERINE CHRISTENSE		41. Oh. Tour est		March	9,	2008					
iner	4a. Facility Name (If not institution, give street and number) Greater Laurel Health & Rehab. Ct		4b. City, Town, or L. Laurel	ocation of Death			County of Death					
1	5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year	f Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign				
r	212-01-3140 1 M 2KF 101	- Yrs.	Months Days	Hours Min.	(Month, Da Apr. 16	y, Year) , 1906	5 Coi	intry) MD				
~	Usual Residence of Decedent		10d. Inside City Limits									
7												
Director	10e. Street and Number	.01	10f. Zip Code			10g. Citizen of What Country?						
Ö	1009 Marton Street	20707				USA		,				
Funeral	11. Manital Status 12. Was Decedent Ever in U.S.						14. Race - American Indian,					
F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give			Specify:	nican, etc.)		Black, White, etc. Specify: White					
d by	3 Nation American States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States States Stat						ореслу.					
Completed	(Specify only highest grade completed)	6a. Decede (Give ki life. Di	ent's Usual Occupati ind of work done du O NOT use retired)	on ring most of worki	ng	16b. Kii	nd of Business/I	ndustry				
l mo	Elementary/Secondary (0-12) College (1-4or 5+)		one Opera			U.S.	.Gov't/I	Dept.of Army				
Be C	17. Father's Name (First, Middle, Last)		1	8. Mother's Name		Maiden	Surname)					
일	George Sporer			Cecella	Franz							
Ι.	, , , ,											
	Patricia A. Haywood/Friend		ition (Name of		Date		cation - City or					
	1 Burial 2 □ Cremation 3 □ Removal from State cem	netery, crema	atory or other place)	Marc	h 13,		_	Town, State				
5	4 □ Donation 5 □ Other (Specify) ST. 21. Signature of Funeral Service Licensee		s Cemeter	_ ,	1	Laurel, MD dson Funeral Home, P.A.						
	Da. Kein Svile M01053	20707	ie,r.A.									
	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.		Approximate interval Between									
,	Immediate Cause (Final disease or condition a Cardia Arrythmia											
ı	resulting in death) Due to (or as a consequent	nce of):										
	Sequentially list conditions. Coronary Art		isease									
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
Examiner	that initiated events c	nce of):					+					
	d											
Medical												
-	## 1FFMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal december 2 □ Fetal decem	eath 3□E	Ectopic pregnancy			1	23d. Date of delivery Month Day Yea					
Completed by Physician	1 ☐ Yes 255No 4 ☐ Pregnant at time of deat 9 ☐ Unknown	.h 5□	Other (specify)				Monar	Day				
Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause given	in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?				
d by	Hyperlipemia				10	Yes 2	No 3□Pr	obably 4 Unknown				
lete					24a. Was		24b. Were au	topsy findings available completion of cause of				
omp					auto perfo	psy ormed? 2	death?	37				
Be C	25. Was case referred to medical examiner?			26. Place of Death								
TO E	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	?/Outpatient		4 LTNursing Ho				cify)				
on:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	8b. Time of Injury	28c. Injury a Work?		28d. Describe	how injur	y occurred					
2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 20 Place of Injury. At home farm street factors office 28f Location /5								(Street and Number or Rural Route Number,				
ertif	4 Homicide determined building, etc. (Specify)	, ram, one	or, radioly, omoc		City or To	wn, State)	, , , , , , , , , , , , , , , , , , , ,				
a C	29a. Certifier 1 Certifying Physician: To the best of my knowle											
edic	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or invi	1		red at the time,		,					
Σ	29b. Signature and title of certifier	YIN	29c. License				te signed (Mont					
	· IVUWIVUAN.		/ D1922	0		Marc	ch 11, 2	8008				
	30. Name and address of person who completed cause of death (Item 23 Neal Meade, MD, 9811 Mallard Dr			D 20708								
tate	31. Date filed (Month, Day, Year) . Registrar's Signature											
trar	MAR 1 2 2008	6004										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 2, Da 2008 Year 8:44 P **Physician** Laura Madeline Lanham Curtis /Medical 4b. City, Town, or Location of Death Edgewater 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner South River Health & Rehab Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 17, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 579 30 8938 1 □ M 2 1 □ M 94 1913 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with n and Mental Hygiene.
is marked other than "natural", or items 23a or 144 Washington Road 21037 Completed by Funeral United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Cafeteria P.G. County Board of ED. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brooke Lanham Susanne Wood ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health an ant; If item 27 is jury or other trau P.O. Box 422 Tracey's Landing, MD Carlton Harbaugh (Friend) 2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) March 11, 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ∭Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD Veterans Cemetery Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d wice Licensee Alexandria Ferry Rd, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ___ each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Tes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☑ No 24a. Was an ate has page 2 s autopsy performed this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ 100 Be 26. Place of Death (Check only one) Hospital: Other: 4☐ Mursing Home 5☐ Residence 6☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical (Check only one) xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D57028 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add m.p. #231 Annapolis MD 21401 31. Date filed (Month, Day, Year) MAR 1 2 2008 32. Registrar's Signature State Registrar

		For State Registrar	State of Marylan		artment of He			iene g. No.2008	07970		
Physi		1. Decedent's Name (First, Middle, Last	Joseph Canzar	ni		· · · · · · · · · · · · · · · · · · ·	2. Date of Death	eath 3. Time of Death 4:08 a M			
/Med Exam		4a. Facility Name (If not institution, give Manor Care Rossy	street and number)		4b. City, Town, or I			4c. County of Death Baltimore			
Funera Directo		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Oec. 5 1	9. Birti 925 Mar	hplace (State or Foreign untry) y l and		
Maryland -f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County Md • N/A	1	y, Town or Lo					10d. Inside City Limits 1√√Yes 2 No		
th with the 23a or 28a st be notif	al Director	10e. Street and Number 910 Fawn Street			10f. Zip Code 21202		10	Og. Citizen of What Co USA	g. Citizen of What Country? USA		
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	panic Origin? (Si , Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: Wh			
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. To is marked other then "natural", or traumatic event, the Medical Exam.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ication le completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done du DO NOT use retired) CPE d [†]		king	16b. Kind of Business/ Restaurant	·		
/land //	To Be C	17. Father's Name (First, Middle, Last) Pio Canzani				18. Mother's Nam ROSā	ne (First, Middle, N Perugini				
and 2 sho ealth and In 27 is me ner traume	ľ	19a. Informant's Name/Relationship (7) Mrs. Pia Kokinakos	s/ Daughter	4003	B Hodges R	d. Monkt	ton, Md.				
Baltimore, Mispermit. Pages 1 and 2 Department of Health a limportant: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☐ Curial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Mos	st Holy	osition (Name of matory or other place / Redeemer	3-14	1-08	Baltimore	, Md.		
Dan permit Depar Impor		21. Signature of Funeral Service Licens		22	2. Name and Address RUCK 1050	Towson F York Rd.	Tuneral H Towson,	lome, Inc Md: 21204			
58760, Icate be executed Examine and physician and entiel-transit entitle.	Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A The re Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	quence of):	ter the mode of dying to Tic Caronic C	, such as cardiac válova j)wlm	n Cislar	Discon Discon	Approximate Interval Between Onset and Death		
Box (Bath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 3 Month Day Yes 2 No 9 Unknown 1 Unknown Unknown 1 Unknown									
Records, P.O. he law requires that the de has been signed by the ge 2 should be detached	Completed by Ph	Part II. Other significant conditions of	entributing to death but not res	sulting in the u	nderlying cause give	n in Part I.	1 ☐ Ye	pacco use contribute to es 2 □ No 3 □ Pi n 24b. Were au	robably 4 Denknown		
Vital Rec slcian: The law certificate has b irector, page 2 s	Be Com	25. Was case referred to medical examiner?					autops perform 1 Yes 2 ath (Check only on	ned? death? 2☐No 1☐Yes	completion of cause of		
Division or Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At houlding, etc. (Speci	28b. Time of Injury	of 28c. Injury Work M 1 \(\supers	4 ELI Nursing H	28d. Describe ho	ence 6 □Other (Spe ow injury occurred reet and Number or Ri n, State)			
e Hospital 24 hours a Funeral	Medical Ce		rsician: To the best of my knotiner: On the basis of examination and manner stated.								
To the within To the comple	Me	29b. Signature and title of certifier	Naun		29c. License	2661		9d. Date signed (Moni	2000		
140		1 0000-10	alm 201-10		CK River	Neck	Road	Baltimere	Hay land 2122		
Regis	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	house						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ам 3/9/2008 James Richard Conway /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 70 Chicago, 11/28/1937 Director 319-30-2639 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 11√ Yes 2 No ns 23a or 28a-f sh must be notified Director MD Prince George's College Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20740 9732 51st Place Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 XYes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No 3altimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 4 Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred A. Sweeney 2 Robert E. Conway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mary_Lou Conway, Wife 51st Place, College Park, MD 20740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/13/2008 4 Donation 5 Dother (Specify) Gate of Heaven Cem. Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Cla udette Vanmag Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Jasch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER LUNG one month **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No funeral director, page 2 should Be Completed Coronavu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Artery 24a. Was an autopsy performed? Yes 22 No Hypertension 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61007 March 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVER SPRING, MD 20903 831 E. UNIVERSITY BLVD #25 KENNETH KHANDAGLE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

State of Maryland / Department of Health and Mental Hygien 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:27 a^M 8 March 2008 Melvin Leroy Dell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manchester

| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 4,1925 Carroll Longview Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** 11€M 2□F Yrs. 82 Director 219-20-3245 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene and control Health and Mental Hygiene ent: if item 2.2 is marked other then "neturel; or iteme 2.3 or 28a-f show ury or other traumatic event, I'm Medical Examinat must he notified at 1 Yes 2 No Maryland Carroll Westminster Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2804 Manchester Rd. 21157 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker 6 Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Dell Edna Giggards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 Department of Health a Importent: if item 27 ie any injury or other trat Betty Dell - wife 1804 Manchester Rd. Westminster, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Lutheran Cem.March 11,2008 Manchester, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Suit Elhal 3296 Charmil Dr. Manchester, MD. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tai **Physician** 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attanding physicien and hed for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by After this certificate has been signe funeral director, page 2 should be 3 Probably 4 Unknown 1 🗆 Yes 2 100 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 10 No 1 ☐ Yes or Attending Physician: 25. Was case referred o medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Usursing Home 5 Residence 6 Other (Specify) 2 12 No Certification: To 1 Yes 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death.
Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerai 6 Hospitai 29a. Certifier 1 (2) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ÷ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H006 1206 08 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANCHESTER ANOVER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RAYTON Month (2)2 Day Year 748 08 16 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ACCO Keek

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Old Cabin Place Georges Prince 5. Social Security Number 9. Birthplace Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Virgina Yrs. 251-82-4405 Director 08/22/1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 1XYes 2 □ No Director Colonial 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be re 23834 みてみり Koad united State by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 Is any Injury or other trau once. 16701 Old Cabin Accokeek drian Dray MD 2060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Retersburg, Wilkerson Memoria 02-22-0 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility J.M Wilkerson Funeral Establishment 102 South Ave Vetersburg, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monther tri /Medical Due to (or as a cons nuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (prisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 2 No 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MAR 12 2008 Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ENSE HGHWAY

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day}2008 **Physician** 5:20 P M March 7, V. Wanda Daniels /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Funeral Days Months 1 M 2 Director 033 16 7946 Usual Residence of Decedent May 13, 1925 Mass filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐Yes Z No Director Maryland | Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 3 20735 United States 6116 Arbroath Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2√T√No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Office Worker Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Civilian Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fil ont of Health and Mental H it; If item 27 is marked oth y or other traumatic even Be ပ Joseph Orwat <u>Victoria Gwizdak</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Daniels (Daughter) 1129 Floyd Ave, Richmond, Virginia 23220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) March 18,2 008 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If any Injury or Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature on Funeral Service License WOI166 23a, Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE HEARIT CON GESTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DISEASE certificate be executed HEART VALVULAR sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE JSe 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? for 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2√√No 9 Unknown Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform has 2 No certificate 1□ Yes Division or Vital 26. Place of Death Check onl one 25. Was case referred to medical examine? Be examine? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient dife မှ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital virthin 24 hours after de To the Funeral Direc 4 ☐ Homicide 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 40324 MARCH 7, 2008 address of person who completed cause of death (Item 23a) (Type, Print)

Y A. JODRIE, MD, 7503 SURRATTS ROAD, CLIMTON, MARYLAND 20735 30. Name and 31. Date filed (Month, Day, Year)
MAR 1 2 2008 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 March 6, **Physician** 10:53 AM Dunn Bobby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1949 North Carolina Yrs. 58 241 78 8379 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2/TVNo Director Maryland Prince George's Clinton 10g. Citizen of What Country? 10e Street and Number 10f Zin Code United States 20735 8406 Blackwillow Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1579s 2□No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: **Black** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Interior Photographer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Hunter Johnnie Dunn ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Clinton, MD 20735 19a. Informant's Name/Relationship (Type. Print) 8406 Blackwillow Court, Clinton, MD Sheila Dunn (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other placement 13, Date 2008 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signalus Funeral Service Lic CH Alexandria Ferry Road, Clinton, MD 20735 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Enter the diseas or heart fallure. Approximate Interval Between Onset and Death 23a. Part1. Immediat Cause I nal disease or condition resulting in death) **Physician** lun Advanced /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line of unwriting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death, Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17.0 24344 6 3.7.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1801 Georgia An Suit 3-41 Silver Sping ROINTAN M.D 31. Date filed (Month, Day, Year)-32. Registrar's Signature State MAR 1 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2008 March 7, 5:35 A William Elson Duvall, III 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1√M 2□F Days Hours 73 212327630 Washington DC Jan 6. 1935 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County 1 ☐ Yes 🔏 No Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 6200 South Osbourne Road 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced XX White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer/ Logger Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Randall William Elson Duvall, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane Duvall (Ex Wife)
20a. Method of Disposition 17101 Aguasco Farm Rd, Aguasco, MD 20608 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State M∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | March 14,2008 | Suitland, MD 21. Signature of Funeral Se 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a, Part | Ente shock, or Immediate Cause usual disease or conditi resulting in death) Due to (or as a consequence of) Sequentially list conditions, in the sequentially list conditions, in the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequ Due to (or as a consequence of): MALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown . Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3☐ Probably 4 ☐Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

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Physician /Medical Examiner The law requires that the death certificate be executed

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite

of Health a item 27 ls

Department of Important: If it any injury or o once.

altimore, Maryland 21215-0036

burial-trai physician use within 24 hours after death To the Funeral Director: completely filled in by the

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

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			26. Place of De	eath (Check only or
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28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	. Injury at Work?	28d. Describe h
		M	1 ☐ Yes 2 ☐ No	

e ide	6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ly		cian: To the best of my knowledge, death occurred at the time, date and place er: On the basis of examination and/or investigation, in my opinion, death occu	

29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) March 7,2008

State Registrar 31. Date filed (Month, Day, MAR 1 2 2008

32. Registrar's Signature 160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4, 2008 12:05AM February Robert William Evans c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci Health Care System VAMaryland Herry roint 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Months Days 1 ☑ M 2 □ F Aug. 29, 1934 Washington D.C. 577-44-3673 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 1 X Yes 2 ☐ No Alexandria Virginia 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 22311 United States 4901 Seminary Road #257 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: Caucasian 3 ☐ Widowed 4 X Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Supply -3-Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Smith Victor Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Labowitz - Guardian 526 King St. #209 Alexandria, VA 22314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 Mag Burial 2 ☐ Cremation 3 ☐Removal from State 3/14/2008 Triangle, VA 4 Donation 5 Other (Specify) Quantico National 22. Name and Address of Facility Jefferson Funeral Chapel of Funeral Service Licenses 5755 Castlewellan Dr. Alexandria, VA 22315 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction cardial Unknown Du lo (or as a consequence of): unknown ertension Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mellitus Diabetes unknown Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate this I hours after death.

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IF FEMALE: 27. Manner of Death 2 Accident 3 Suicide

29a. Certifier

25. Was case referred to medical examiner?

6 ☐ Could not be 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier Hastr

29c. License number

29d. Date signed (Month, Day, Year) 24,2008

Kerry Koint Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, VA Maryland Health Care System m.D. Hashmi

31. Date filed (Month, Day, Year)

MAR 12 2008

State

Registrar

		-	For State Registrar	State of Maryl		tificate of L			Reg. No. 2 () ()	8 07978			
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بندن	Director		220-18-2805 Usual Residence of Decedent	8	Name of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state			Nov. I	3,1926	Maryland			
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Baltimore,	of F of F rot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Dispo cemetery, crer	sition (Name of matory or other place 11 Cemete	erv 03-1	Date 3-08	20c. Location - Cit	y or Town, State Park, Maryland			
Baltir	permit. Pag Department Important: I any Injury o	Cedar Hill Cemetery 03-13-08 Brooklyn Par 21. Signatureyof Fuleral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Mary											
В,		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
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11	1 1		30. Name and address of person who ANGELITE EST.	completed cause of death	(item 23a) (Type, 3 00 / 5 .	HANOVE	ne st. 1	BALTI	MORE, 1	9,2008_			
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 2 21	32 Registrar's	Signature	ach	· · · · · · · · · · · · · · · · · · ·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 Harry Virgil Gantt morch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore Sinei Hosnitel Boltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □XM 2 □ F MD. 12-18-1934 216-30-4435 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Randallstown Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21133 USA 3909 Brenbrook Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married African-American 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Northrop Gruman Packer 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Virginia Chew Alexander Gantt ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Brenbrook Drive, Randallstown, MD 21133 Stella Gantt/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-15-08 Woodlawn Cemetery Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses andou 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metostatic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if you had been go in mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 2 LINO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Drath 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death. To the Funeral Director: After filled in by the

> State Registrar

completely

the

Medical

31. Date filed (Month, Day,

29a. Certifier

29b. Signature and title of certifier

29c. License number RESOOD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sincillospitos

32. Registrar's Signature

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Boltimore, 2401 W. Belvedere Avi, Baltime

			For State Registrar	State o	of Maryla		artment of H			iene g. No.2 (008	07980		
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- MANAGES	Funeral	31-92	Social Security Number 6. 8		7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl	ace (State or Foreign		
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Ba	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		+ Kanner	XX	rahe	an 4:	300 Waba	ash Ave			Md	21215		
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	Sta		31. Date filed (Month, Day, Year)	9	gistrar's Si	gnature	market !							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month avid over 1012 M 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimare edice Himore lercy 0 If Under 24 Hrs. 8. Date of Birth (Month, Day, 7/16/ 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min. 10€M 2□ F 219-52-9678 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mantal Hygiane. Important: If item 27 ie marked other than "naturel", or itema 23s or 28s-f show empiriupry or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD N/A Baltimore X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21202 716 Mura Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1√2 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry N/A Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Lee Glover Baker Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5108 Arabia Avenue Balto, MD 21214 Tracey Hedgepeth - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem 3-1-2008 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. E. North Avenue Balto, 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Probable oronar /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of or Attending Physicien: The law requires that the deeth certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) after death. I Director: After this certificate hes been signed by the a d in by the funeral director, page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ inknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29b. Signature and little of central 29d. Date signed (Month, Day, Year) \$\$690Z4 who completed cause of death (Item 23a) (Type, Print) Place Sche MD 301 Stephen

Registrar
DHMH 17 Rev 1/2001

State

31. Date flied (Month, Day, Year)

MAR 12

2008

32 Strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Physician Month March 2, 12:55 AM Naomi Morton Grabus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Apr 21, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 💢 F 1921 Director 86 489-26-1773 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Bel Air MD Harford 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21014 USA 304-J Canterbury Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 education teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark Morton Edna Bradford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun 1311 Holly Street NW Washington, DC Susan Myatt/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee
Ronald S. Wade, Director
Ronald S. Wade, Director
State Anatomy Board 655 W. B.

Raltimore, MD 21201

23a. Part. Enter the diserie, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dille to (or as a nonsequence of) burial-transi Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After ti 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 03(08

Registrar

DHMH 17 Rev 1/2001

State

Maryland 21215-0036

Baltimore,

Box 68760

Records. P.O.

Division or Vital

GRABUS

NAOMI MORTON

a.m.

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

					y				Death		Reg. No.) (11903			
			1. Decedent's Name (First, Middle	, Last)						2. Dete of De	eth		3. Time of Death			
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	/Medio Examir		4a Fecility Neme (If not institution	, give street end number))				4b. City, Town, or I	ocation of Deatl	4c. County of Death					
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	Funeral Director		5. Social Security Number 217–24–7276		ge <i>(In yrs.</i> . 81	lest birthday) Yrs.	If Unde Months	r 1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 2	th Yeer) 7, 1926	Birthpla Count MD	ace (Stete or Foreign (y)			
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d 21215-0036 filed within 72 hours after death with the Mandand	penimi. rages i am 2 should be find writh? Indus after beath with the waryer logarithms of Hailih and Mental Hygiens institute!, or flem 23a or 28a-f show important: if flem 27 is marked other than "natural", or flem 23a or 28a-f show any Injury or other traumatic event, its Medical Examinar must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3X□ Widowed 4 □ Divorced	Armed Forces?	,			No	Specify:	o Rican, etc.)	Bleck,	ck, White, etc. y: White				
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I RECORDS, P.O. BOX 68/60, The law requires that the death certificate be executed.	been signed by the attendin should be detached for use	Completed by Physician/								10	Yes 2□No 3	Prob	ably 454nknown			
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			30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) TARIQ MAHMOUD 19, Rid de Road We							5	,2/11	108	5			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- Registrar #8 &19a Per FH G877 3/12/08 JH
Reg. No.
Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 031 A ULA manch 2002 7. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IA BIDDLE 57 ALTO 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 ☐ M 2 🗷 E Months Days Hours Min. OCCU.16 218-44-4051 Director MO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1⊠Yes 2 No Funeral Director BALTO MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 U3A 2200 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 202 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CLERK CLENK 1273 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental and Menta LULA STE VENSON KhIA 2 Informant's Name/Relationship (Type. Print) **Betty Johnson** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO Department of Health Important; If item 27 BIBBLEST MD 21213 200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) (em 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thien Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician una /Medical Due to (or as a come Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Nnknown 1 🗌 Yes Completed director, page 2 should been 24a. Was an autopsy performed2 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has t 2X No this certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) completely filled in by the funeral Manner of Dath 27 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

29a. Certifier

29b. Signature and title of certifie

TUU 31. Date filed (Month, Day, Year)

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type,

1 2 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Elizabeth A. Gillespie 11:12 A 03 08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Falls, 7914 Bradshaw Road Maryland Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under Hours Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2 💢 F Director 70 05/15/1937 Maryland <u>212-36-5076</u> 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Upper Falls 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21156 7914 Bradshaw Road by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene. n 27 is marked other than "natural", or Itel 1 ☐ Yes 2**X** No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 XWidowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel W. Haase Elizabeth Andersen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a 21236 17 Virginia Avenue - Baltimore, Maryland Danielle McHugh (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If Ite
any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Memorial Pk. 03/13/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Ci I مــٰث 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mon Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 27 No 1 □Yes 2 □ No. 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of eath 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Natural 2 Accident 5 Pending investigation

and Division or Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria certificate has been Hospital or Attending Physiclan: this

completely filled in by the funeral director, page 2 should be within 24 hours after death. To the Funeral Director: After

show

death with

Baltimore, Maryland 21215-0036

29a. Certifier

3 ☐ Suicide

4 ☐ Homicide

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be

determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ∏Yes 2 ∏No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Towsoutown Blud tauluer MD 555 W. 31. Date filed (Month, Day, Year)

State Registrar

MAR 12 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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To the

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For amend #8 Per FH G877 3/14/08 JH Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg Not 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Year **Physician** D7AM Adam Francis Gwiazdowski 2008 /Medical 4a, Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health Belfir BelAir Kehab. tart 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number .Sex X⊓M 2□F 8. Date of Birth 1927 (Month, Day, 1927) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Yrs. 9-23-±9 Md. 217-20-5073 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Md. Baltimore 1 ☐ Yes 2 ☐ Made Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 832 Seneca Park Rd. 21220 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: 3√ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Fiberglass Company Carpenter and Mental Hygie Department of Health and Mental Hygin Important: If Item 27 is marked any Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Injury or early Inju 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Gwiazdowski Alice Marie Leggen ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Ford 2416 Parliament Dr. Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 5 Other (Specify) 4 □ Donation Rosary : 22. Name and Address of Facility 3-12-2008 Baltimore ,Md 21. Signature of Fundral Service Acer Schimunek Funeral Home 9705 Belair Rd. 21236 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that coust of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying to or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for 1 in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2 ☐ No been signed by the should be detached Records, P.O. 9 Unknown 9 Unknown Part to ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an page 2 autonsy perform certificate 1□ Yes 2√ No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. tdam within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or A hin 24 hours after 1 Sertify in Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and son who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 3:35 QM Bure 03 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A maryland Baitimore University of Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 18, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🙀 F Massachusetts 088-12-6840 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is anawled other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. Nassau Malverne New York 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11565 USA 46 Alnwyck Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Business Manager Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sam Bennett Sadie Kahl ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Gull / Son 25917 Spring Farm Circle Chantilly Virginia 20152 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Pinelawn Memorial Park Pinelawn New York 3/12/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 5305 Harford Road Baltimore Maryland 21214 Muster 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Seudomonas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): ate has been signed by the aftending physician page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Ventilator departence 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an End stage rena autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital (within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/08

Registrar
DHMH 17 Rev 1/2001

Danica

31. Date filed (Month, Day, Year)

6 reene

32 Registrar's Signature

3altimore MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOIN Larch (0:20P M 08, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** N/A BON SECOUR HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) 3-16-1982 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 √M 2 □ F MARYLAND 216-98-4997 25 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show 1 XYes 2 ☐ No "natural", or items 23a or 28a-f shedical Examiner must be notified Director BALTIMORE MD. N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 1811 S. WILHELM ST. 21223 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CLERK STORE Health and Mental Hygicem 27 is marked other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be MARCELINE SPARROW 2 MARK D. GARY SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health au Important; If Item 27 is any injury or other trau once. 1811 S. WILHELM ST. BALTIMORE, MARYLAND 21223 MARCELINE GARY (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2/Crema 3 ☐Removal from State 3-13-2008 BALTIMORE, MARYLAND MT. ZION CEMETERY 4 Donatio 5 Qmer (Specify) 21. Sign JONATHAN D. HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME P.A. ral Service Licen 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, str. ck or heart failure. List only one cause on each line. ndromp Imme nate Cause (F diseas condition resulting in death) Cause (Final acquisod DMMUNO do **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transi Exam Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Sepsis Syndrome 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pinous Completed

26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

25. Was case referred to medical examiner? Be 1 ☐ Yes 2 📜 No 2

27. Manner of Death

5 ☐ Pending investigation

2008

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

BULTMULL

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Bultimore STrut 2000 WOST 32. Registrar's Signature 1000

completed cause of death (Item 23a) (Type, Print

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

page 2

funeral director,

Certification:

Medical

certificate

this

within 24 hours after death.

To the Funeral Director: After of completely filled in by the funeral

or Attending

To the Hospital

DHMH 17 Rev 1/2001

State

Registrar

14

31. Date filed (Month, Day, Year)

MAR

112

32, Registrar's Signature

Day 501

A SOL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month PM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Assisted Living Facility - 6359 Rising Moor Howard Columbia 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2▼F 216-14-8901 Director January 27, 1922 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director Howard Jessup Maryland 10e. Street and Number 10g. Citizen of What Country? Aspenwood Way USA 20794 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Bus Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be It of Health and Mental William Pearson Grace Groshens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8151 Aspenwood Way Jessup, MD 20794 Michael Healey Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō f ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department o Important: If any Injury or Anatomy Gifts Registry Hanover, MD 4 Donation 5 ☐ Other (Specify) March 7,2008 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to finme disticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examiner and The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 ¶Unknown 1 🗌 Yes Completed FLEXION CONTARTURES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 When (Specify) ASSISTALLIVES Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide o the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) Silverstang Maryland 12201 Blumena

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per fb 877 3-11-08 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Μ. Hopson 5 Y. YOA marac H २७०४ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ttospital

7. Age (In yrs. last birthday) NA UNION Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 🗷 F 51 220-64-1135 Director 07-24-56 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD 1 Yes 2 No Director Baltim 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ddle 21213 E.B. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2. ☐ If Yes, Give Year or Dates: 2. No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced BLack permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Industry College (1-4or 5+) Elementary/Secondary (0-12) Variou aborer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel 2 ienneth Mae Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth L. Hopson-Bal M1)21213 timore, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Wan PK3/10/08 4 Donation 5 DOther (Specify) Laurel, Maryland 22. Name and Address of Facility
Chatman-Harris Funeral
Read 21. Signature of-Funeral Service Licensee Home 910 Baltomore, MD 21206 mo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** الاجع IND /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con Physiclan; The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Bacumpath € No 1 Tyes 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA Uppatient Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Injury 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Types Print)

State Registrar 31. Date filed (Month, Day, Year)

MAR

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month 3 **Physician** 56 AM AVID 2008 HARDY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMO E

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Secours Birthplace (State or Foreign Country) Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Month 25-1965 1√2 M 2 □ F Yrs. MD 42 Director 218-82-9934 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County YYes 2□No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 21216 USA death v Funeral 2100 N. ROSEDALE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or iteally or other traumatic event, the Medical Examiner 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECURITY GUARD HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHRISTINE BLACKWELL ERNEST HARDY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 B & A BOULEVARD, SEVERNA PK., MD 21146 LEE HARDY, JR/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If It any injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3/12/2008 BALTIMORE, MD METRO 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Sign turn of Service Licenses 1701 LAURENS ST., BALTO., MD 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mrshm /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, any later cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician a the burial Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 Probably 4 Unknown 1 □ Yes Be Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has birector, page 2 sl autopsy performe death? 1 ☐ Yes 2 No 2 MO 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Waturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral D stely filled in hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29c. License number 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

1940

W. BAt. ST, RACT NO 21223

who completed cause of death (Item 23a) (Type, Print)

32 Aegistrar's Signature

08-01687 Terry Harris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Physic	ian/	1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Certifica						Reg. No.	200		
dical Exam		TERRY HARRIS						2. Date of De Month February		Year)8	3. Time of Death 2000 hrs	
		4a. Facility Name (if not institution, give street and number) University Hospital		41	. City, Town, Baltimore		n of Death		4c. 0	County of Death	1	
Funeral Director		219-70-0888 1X M 2 F	(In yrs. last birti	hday) Yrs.	If Under 1 Y	ear If Un ays Hou	der 24Hrs. urs Min.	8. Date of B		Co	thplace (State or Foreignatry)	
w any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Locatio	n						10d. Inside City Limits	
aryland 8a-f show at once,	ģ	MD N/A 10e. Street and Number						1 X Yes 2 No				
th the Maryland 23a or 28a-f sho notified at once	Director	525 WYANOAK AVE.			10f. Zip Code 212			ntry?				
3 72 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	Ever in U.S.	13. Was	Decedent of Hispanic Origin? (Specify Yes or No- s, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.					ican Indian, Black,		
rs after de rral", or miner mu	by	3 Widowed 4 Divorced of Yes 2 X No 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of world)							s		BLACK	
× = = ×	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) -12- -0-	College (1-4 or 5+)			pation (Giv ife. DO NO	e kind of wo T use retire	ed)		ond of Business/	•	
Z I Z I D-00.	Be	17. Father's Name (First, Middle, Last) UNKNOWN				1		me (First, Middle, Maiden Surname			RIAL HOSPI	
permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other tranmatic ev	To	19a. Informant's Name/Relationship (Type, Print) RENEE HARRIS (DAUGHTER)	19 b	. Mailing <i>A</i>	Address (Str ELOIS	eet and Nu	ımber or Ru	ral Route Nu	mber, City	or Town, State	, Zip Code) 1040	
Dealtiffole, Dermit. Pages I and Department of Heal Important: If iten		20a. Method of disposition 1 X Burial 2 Cremation 3 Removal from State	~	f Disposition	on (Name of or place)	cemetery,		Date	20c. Lo	cation - City or	Town, State	
mit. Pa partmer portan ury or		4 Donafron 5 Other Specify: 21. Significant of Funeral Service Licensee 10 Marsh XV			CEMETE		3-6-		BAL	TIMORE,	MARYLAND	
Trate be executed g physician and the burial - transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Industryin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq d	uence of): -f. perME	5/15/08	TT							
death certif	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at tir 9 Unknown	of pregnancy 2	Fetal	death 3 r (Specify)		ic pregnand	;y		Date of delivery lonth E	Day Year	
ires that the signed by	δ	Part II. Other significant conditions contributing to death be	out not resulting	in the und	derlying cause	given in F	art I.				the cause of death?	
ial or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should h	Completed							24a. Was autor perfo	osy ormed?		topsy findings available ompletion of cause of	
ysician his certi director	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient	2 FR/Out	tpatient 3		Other;	(Check on		D			
ding Phy. h. : After the funeral	on: To	27. Manner of Death 1 Natural (Month, Day, Year		ime of Inju	ry 28c. Inj	ury at Wor	k? 2	Home 5	Residenc how injury			
ospital or Attend hours after death meral Director: y filled in by the	Certification:	2 Accident Investigation 3/31/200/ 3 Suicide 6 X Could not be 28e. Place of Injure	y - At home, fan nil			Yes 2 y	tc. 2	unk Bf. Location (520 Town, N	Street and	Number or Ru	ral Route Number, City	
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my k one) 2 Medical Examiner: On the basis of examination and manner stated.	nowledge, deat	h occurred vestigation	at the time, on an an an an an an an an an an an an an	date and pl	ace, and du	e to the caus	se(s) and r	nanner as state	ed	
	Ĭ	29b. Signature and title of certifier Authorities			29c. Licen	se number				9d. Date signed (Month, Day, Year) February 28, 2008		
	ľ	30. Name and address of person who completed cause of dear Laron Locke MD. Assistant Medical Exam	iner 111	Penn S	treet, Balti	more. M	ID 21201					
Sta Registi		31. Date filed (Month, Day, Year) 32. Resistrar's		1.	AP.	-1						

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Reg. No.												
н	Physici	an	Decedent's Name (First, Middle, La	·					2. Date of De Month		3. Time of Death				
1	/Medio	al	Baoqun 4a. Facility Name (If not institution, given	Huang		1 41	h City Town	n, or Location of Deat	March	5 200 4c. County of De	08 3:30 p ^M				
1	Examir	ier	Ellicott City Hea	,				ott City	'	Howard					
	Funeral Director		575-13-3222	Sex 7. Ag 1.24 M 2F	je <i>(In yrs. l</i> as <i>t l</i> 95		f Under 1 Ye flonths Day		8. Date of Bir (Month, Da Feb • 28	th ly, Year) 3,1913	irthplace (State or Foreign Country) China				
	land bw t		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Locati	ion	· ·			10d. Inside City Limits				
	a-f sho	į	MD Howard		Ellic	ott C	ity				1 □ Yes 2 □XNo				
	h with the	Funeral Director	10e. Street and Number 3540 Lowlen Cour	t			10f. Zip Cod			10g. Citizen of What USA	Country?				
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			s Decedent ces, specify C	of Hispanic Origin? (Suban, Mexican, Puer No <i>Specify:</i>	pecify Yes or No to Rican, etc.)	14. Race - Ar Black, W Specify:	nerican Indian, nite, etc. Asian				
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aryl	shoule and Me s mark umatie	To	19a. Informant's Name/Relationship	Type. Print)	19	9b. Mailing A		er, City or Town, State	, Zip Code)						
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Oa. Method of Disposition Date D												
Ball			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee												
в			23a. Pad1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each li	the death. Done.	o not enter th	he mode of o	dying, such as cardia	or respiratory a	rrest,	Approximate Interval Between Onset and Death				
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1 Inpatient 2 ER 27. Manner of Death 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year)								njury at Vork?		how injury occurred	ресігу)				
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<u> </u>	With Con	Σ	29b. Signature and title of certifier Symp 30. Name and address of person who Shakun HACA 31. Date filed (Month, Day, Year) MAR 1 2 2	\ o N n			29c. Lice	ense number		29d. Date signed (Mo	nth, Day, Year)				
,	,		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Prin	I DO	05315	0	MARCH	1 2008				
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DHMH 17 Rev 1/2001

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	Physicia	an	1. Decedent's Name (First, Middle,	Madel	Madelon Bernice Johnson				ath Da	ay Year	3. Time of Death			
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-	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, c	or Location of Death		40	c. County of Death				
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ß	Funeral Director		5. Social Security Number 215–32–5845	4 T 14 AFR	(In yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sept.	th i <i>y, Y</i> ear 20	r) Cour	place (State or Foreign atry) MD			
	pu ,		Usual Residence of Decedent		10- C'- T						01 1-11-01-11-11-1			
	anylar show d at	_	10a. State 10b. County	ltimore	10c. City, Town or Lo Parkvi					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	e Ma Ba-f	5		ICIMOLE	Faikvi	1								
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	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No)-	14. Race - Americ				
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<u>a</u>		L OF	Albert Meyers				Grace	Thomas	}					
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<u>S</u>	death.	icat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could no	t be	ry - At home, farm, str			28f Location (Street	and Number or Rura	al Route Number			
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DHMH 17 Rev 1/2001

Registrar

MAR 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Robert Joseph Jones, Jr. 10:35AM 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Director 213-62-3684 54 Sept.20, 1953 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d, Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1. Yes 2 No Maryland Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA 718 N. Port Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☐ No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Private Industry College (1-4or 5+) Construction Worker and Mental Hygin is marked other 10th grade 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert J. Jones, Sr. ပ Alma Bundy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 of Health a Item 27 i Selena Jones/Daughter N. Milton Avenue Baltimore, Md 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of I Important: If Ite any injury or of 3/11/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Furieral Service Licen de. 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician months Pa /Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2₽ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify Tospice Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 12 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

March 7, 2008

N. Eutan St Balfimore MD 21201

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Box	leeth certific ettending pl	an/N	23b. was decedent pregnant	23c. If yes, outcome of	of pregnan	cy death 3.⊡	Ectopic pr	egnancy				23	d. Date of del		
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	urs el		202 02-25-2												
	To the Hospital or Attending Physician: within 24 hours stelled death. To the Funeral Director: After this certific completely filled in by the funeral director,	edlcal	29a. Certifier 1	sician: To the best of ner: On the basis of and manner stat	examinatio	ledge, death on and/or inv	occurred restigation,	at the tim , in my op	e, date ar inion, dea	nd place, a ath occurre	and due to the ad at the time,	cause(s) a date and p	nd manner as tace, and due	s stated. e to the cause(s)	
	To the within rough	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Mont	h, Day, Year)	_
) (M	PI:	1922	17 01	673	31	917001	6	
•	C+1		30. Name and address of person who co			23а) (Туре,							, , , , ,	<u> </u>	_
_	2''		Colleen Gibson	0 2	7	South	ore	en	24.	Ba	Himory	MO	>		
	Sta		31. Date filed (Month, Day, Year)	R 1 2 2008		res	- E	A Sec	(B)						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH Year 4:51 PM JAY SR. JOHN 2008 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL MARBOR N/A 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 12,1939 . Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours 1**⊠**M 2□F 217-34-9668 68 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A Maryland 1 XYes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code U.S.A. 1622 Patapsco Street 21230 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Specify: White 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 M No 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Baltimore Rebuilders 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amiel Jay Irene Lowery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Patapsco Street, Baltimore, Maryland 21230 of Disposition (Name of Date 20c. Location - City or Town, State Esther Acton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery | 03-11-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 East Fort Avenue, Baltimore, Maryland 21230 21. Signature of Funeral Service License Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) PNEUMONIA, RESPIRATORY FAILURE 25 days ANDIDA Due to (or as a consequence of) ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

ages 1 and 2 should be filed within ent of Health and Mental Hygiene.

It: If item 27 is marked other than "
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permit. Pages 1
Department of H
Important: If iter
any Injury or ott

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

attending physician and for use as the burial-trai

eath certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical Certification: 10

The law requires that the d	sate has been signed by the page 2 should be detached	
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.	To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	

75.14	contributing to death but not resulting in the underly FALLURE	ring cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3☐ Probably 4 ☐ Unknown
COPD			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)		
1 Yes 2 No	Hospital: Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
18/1	$M \cdot D$.	RES 000	MARCH , 5, 2008

State Registrar

Medical

PANWAR, N. Year) 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300)

SOUTH HANOVER STREET, HARBOR HOSP. BALTIMORE, M.

MARCH , 5,2008

DHMH 17 Rev 1/2001